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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

09175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green meadows, Hyatts. 16 X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San.</u>				e. STREET ADDRESS <u>6517 Seigo Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>Cleveland</u> Middle <u>(n. mn)</u> Last <u>Alsep</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-08</u>	9. AGE (In years last birthday) <u>51</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop mgr. Light warehouse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>La.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>James S Alsep</u>				14. MOTHER'S MAIDEN NAME <u>Lelia E. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW2. Air Force</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Hosp. Record</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive myocardial infarction</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>8/8</u> , 19 <u>59</u> , to <u>8/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/8/59</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7105 - Riggs Rd</u>							
DATE SIGNED <u>8/9/59</u>							
ACTUAL SIGNATURE <u>High W. Ire</u>							
M.D. <u>  </u>							
PHYSICIAN'S NAME (Type) <u>High W. Ire</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Virginia</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ther. H. Hines</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
ADDRESS <u>2901 - 14th St S.W. Washington D.C.</u>				DATE <u>AUG 11 '59</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Office of registration: _____</p>	

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

9233

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bronley</b> Last <b>AMMON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-02</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William L. AMMON</b>				14. MOTHER'S MAIDEN NAME <b>Nettie RIECHLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1923 to DOD</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture dissecting aneurysm, aorta</b> <b>45Mx</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>2:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-16-59</b>							
ACTUAL SIGNATURE <b>B. C. Johnson</b>		M.D. <b>U. S. Naval Hospital</b>					
PHYSICIAN'S NAME (Type) <b>B. C. JOHNSON, LCDR, MC, USN</b>		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b> ADDRESS <b>3072 M St. NW, Wash. DC</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kears</b>	

Deputy Medical Examiner, Montgomery Co., notified.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the funeral director, and completely filled in by the funeral director, then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09177

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mont Co. Gen. Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Irving Athey</b>				4. DATE OF DEATH <b>Aug. 8, 1959</b>		19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/1897</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Snowden Athey</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Athey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <b>8/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Carvalham Laurel Md</b>				24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
22d. LOCATION (City, town, or county) <b>Burtonsville Md</b>				22e. (State) <b>Md</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]  
MARRIAGE: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
MILITARY SERVICE: [illegible]  
PREVIOUS ILLNESS: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

DECEASED'S RESIDENCE



Frank J. Woodward

JUL 2, 1950

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

9237

# CERTIFICATE OF DEATH

Reg. Dist. No.

09178

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>5617 M c Lean Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cecil M Bac on</b>		4. DATE OF DEATH Month Day Year <b>Aug 19 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/74</b>
9. AGE (In years lost birthday) <b>85 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN JOS EPH MC kee</b>		14. MOTHER'S MAIDEN NAME <b>ANNA HAM ILTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Cardiac Tamponade</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture, left ventricular wall</b> (c) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Immediate</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Generalized Atherosclerosis</b>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG 14, 1959</b> to <b>AUG 19, 1959</b> , that I last saw the deceased alive on <b>AUG 14, 1959</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo M. Curtis</b>		ADDRESS (Street, city or town, state) <b>8217 WISCONSIN AVE BETHESDA MD</b>	
PHYSICIAN'S NAME (Type) <b>Leo M. Curtis</b>		DATE SIGNED <b>8-19-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>

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1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar  
9. Date of registration

9238

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Mary</b> Last <b>BAKER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-90</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel WELDIE</b>		14. MOTHER'S MAIDEN NAME <b>Margaret LANHAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(S) R.E. Baker, 5409 Fremont St. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Ventricular Fibrillation</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>10 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 30, 1959</b> , to <b>August 30, 1959</b> that I last saw the deceased alive on <b>August 30, 1959</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. I. Shugoll</b>		DATE SIGNED <b>8-31-59</b>	
PHYSICIAN'S NAME (Type) <b>G. I. SHUGOLL, LT, MC, USN Bethesda, Md.</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-3-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Demaine Funeral Home, 520 S. Wash. St.</b>		24. REC'D BY REGISTRAR <b>SEP 3 '59</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/58

8338

EXHIBIT OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG248 9-18-59 et

## CERTIFICATE OF DEATH

09180

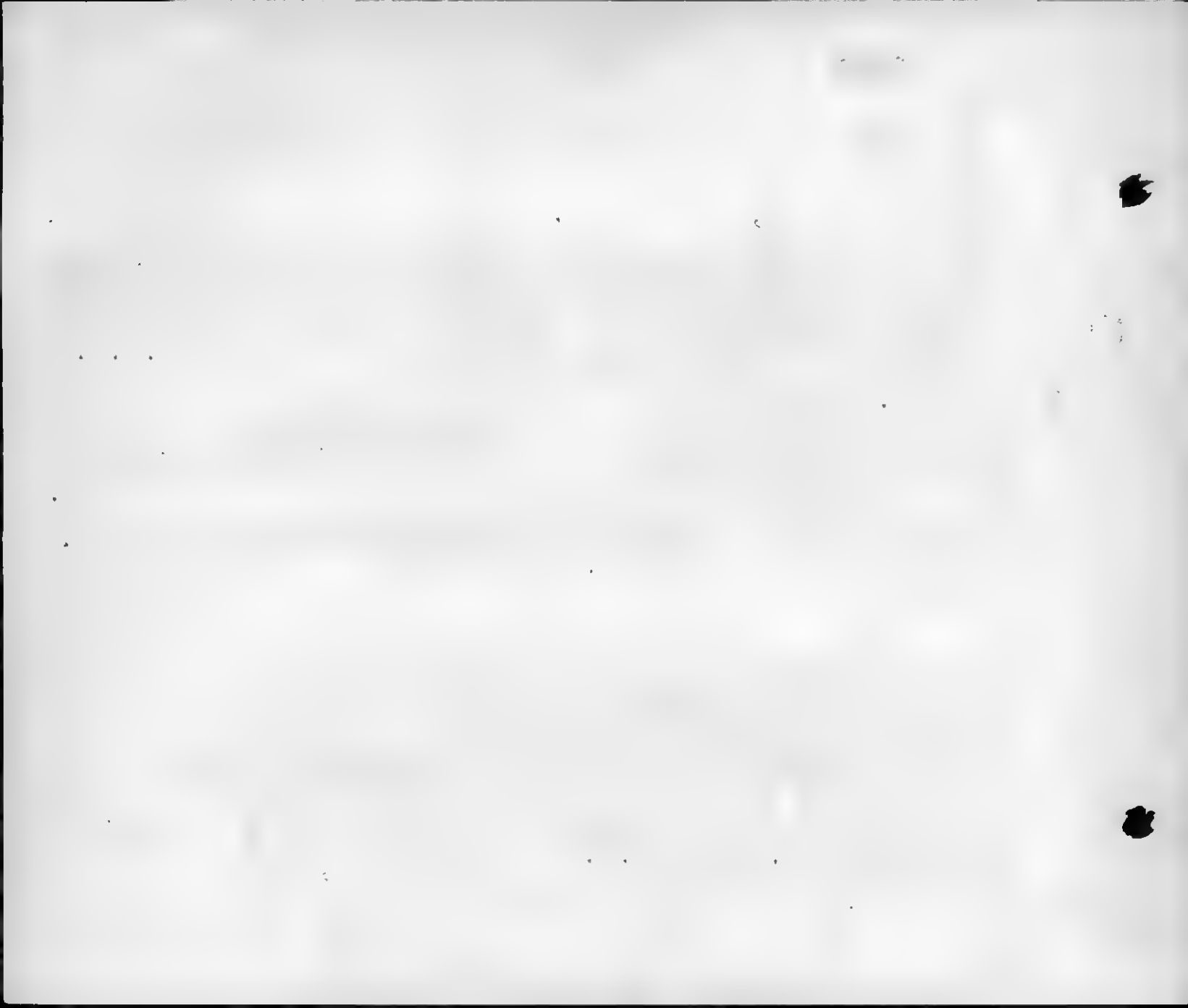
9239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Lancaster</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN IB <b>30 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Walton</b> Last <b>Ball</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17, December 12, 1902</b>	
9. AGE (In years lost birthday) yrs. <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>George L. Ball</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Ford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Melanoma with metastases to the heart (primary, skin of the back)</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>6 mins.</b> <b>6 mos.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 6, 19 59</b> to <b>August 5, 19 59</b> , that I last saw the deceased alive on <b>August 5, 19 59</b> and that death occurred at <b>3:05 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-5-59</b> ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M. D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>8-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Church</b>		22d. LOCATION (City, town, or county) (State) <b>WEEMS, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>EMORY W. HAYNIE, JR.</b>				ADDRESS <b>KILMARNOCK, VA</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	
24a. REC'D BY REGISTRAR <b>AUG 10 '59</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 40 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



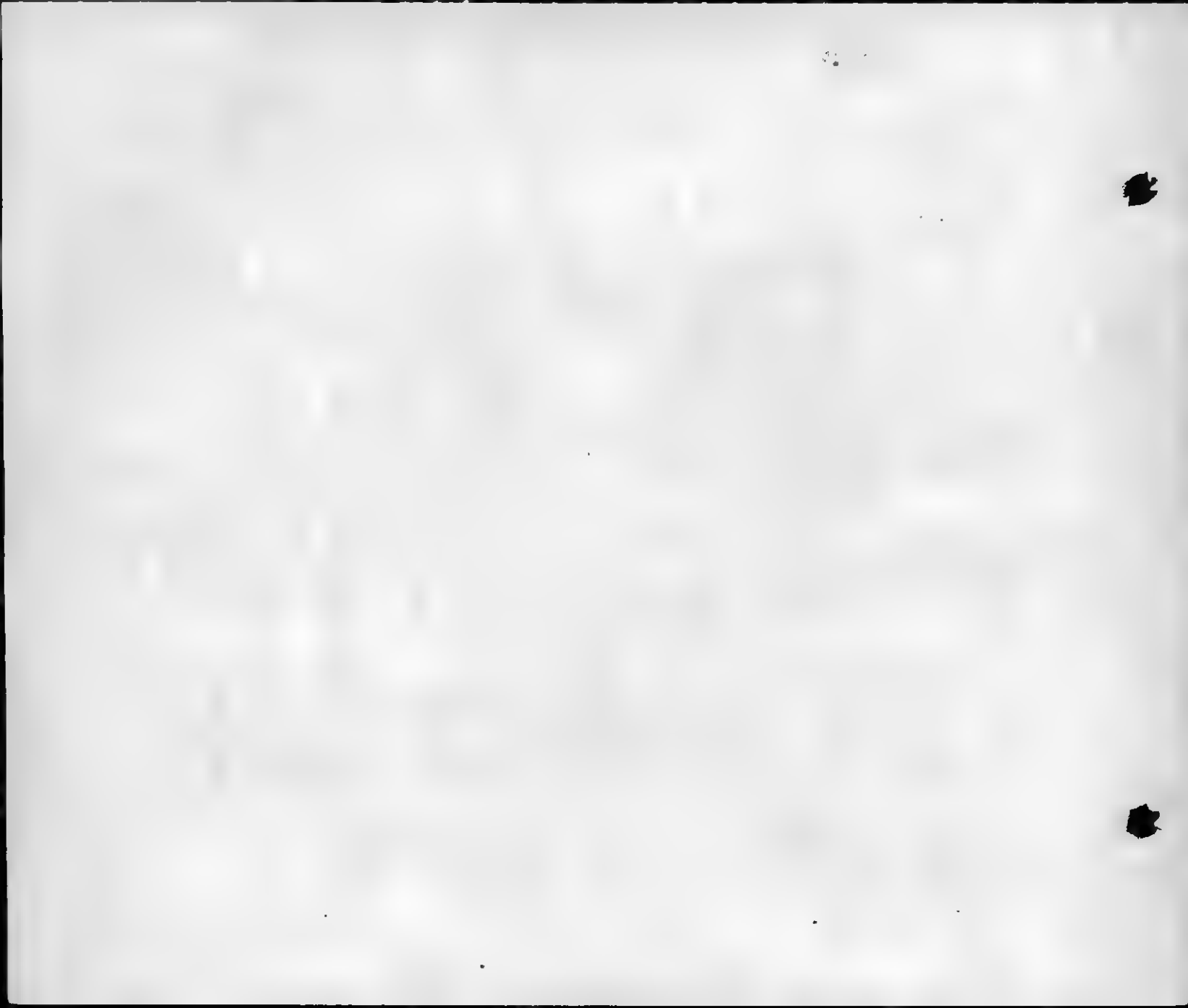
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09181

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood - rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood - rural</u> d. STREET ADDRESS <u>R.F.D. #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Williams Floyd Ballenger</u> First Middle Last <b>4. DATE OF DEATH</b> <u>Aug 19 1959</u> Month Day Year				<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-11-1901</u> <b>9. AGE</b> (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farmer</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>				<b>13. FATHER'S NAME</b> <u>Wm H. Ballenger</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Coffman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>Yes 1925 1928</u> <b>16. SOCIAL SECURITY NO.</b> <u>579 44 1570</u> <b>17. INFORMANT</b> <u>Edna Ballenger (wife)</u> Address <u>Derwood</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO (b) <u>bullet wound in rt temple</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted bullet wound rt temple</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>Aug 19 1959</u> Hour <u>1:30</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>farm</u> <b>20f. (City or town)</b> <u>Derwood</u> <b>(County)</b> <u>Monty</u> <b>(State)</b> <u>Md</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>8-19-59</u> <b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Aug. 22 59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lake View</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Hamilton</u> <b>(State)</b> <u>Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ray W Barber</u> <b>Laytonsville, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <u>Aug 24 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>James L. Hume</u>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9241

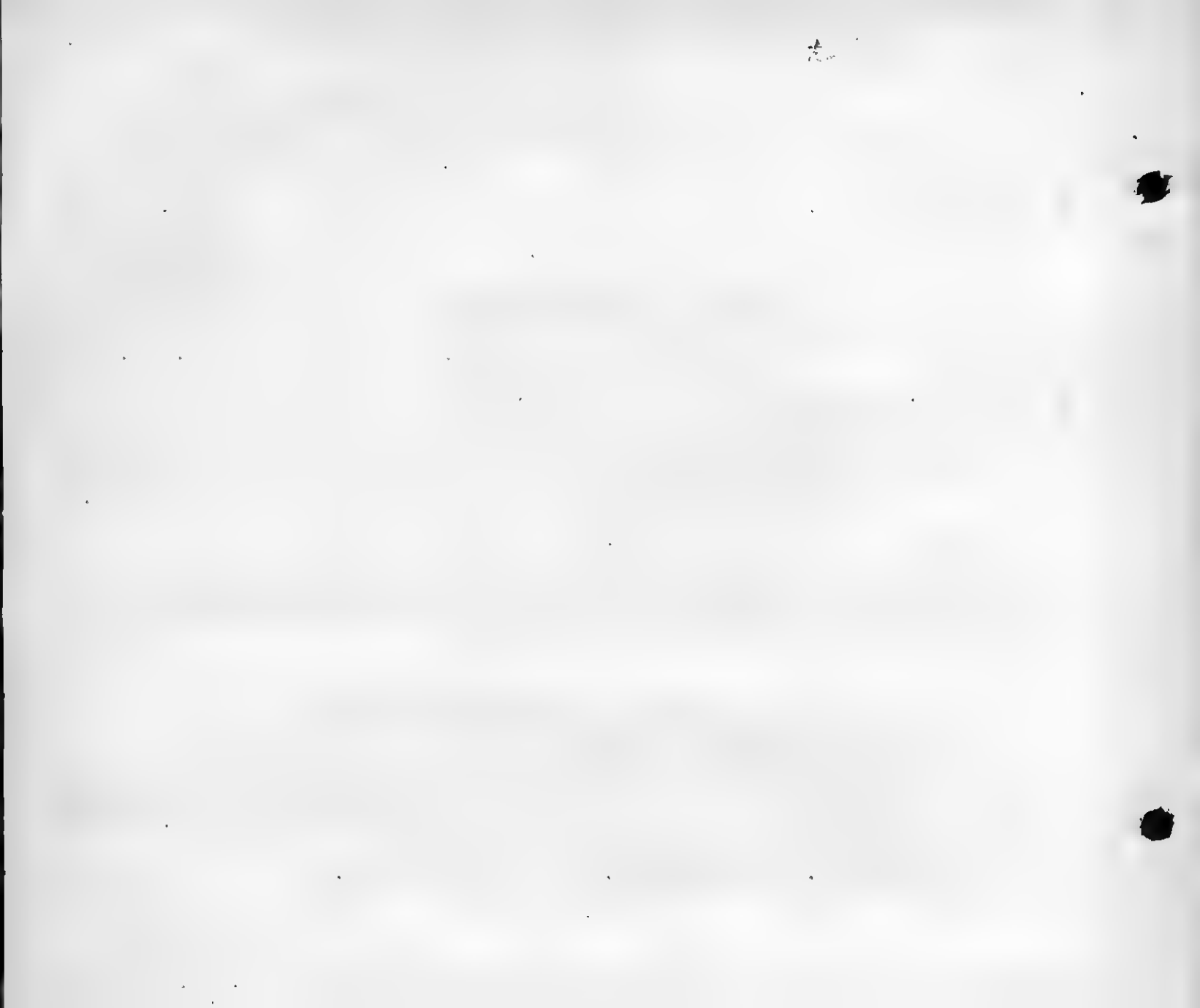
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
f. STREET ADDRESS <b>24 Hesketh Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Miriam G Bartlett</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 16 1869</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>12 Hrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James O. Bartlett</b>		14. MOTHER'S MAIDEN NAME <b>Olive Little Rogers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miriam Hoffman - Item #2- niece</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>parkinsonism, Bronchopneumonia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>parkinsonism, Bronchopneumonia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 14</b> , 19 <b>59</b> to <b>August 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 26</b> , 19 <b>59</b> , and that death occurred at <b>6:40 a</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>August 27, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		<b>Kensington, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Cremation</b>	22b. DATE THEREOF <b>8/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 28 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9242**  
**CERTIFICATE OF DEATH**

09183

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> <span style="float:right">b. COUNTY <u>Mort gomery</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Beall</u>				<b>4. DATE OF DEATH</b> Month <u>8.28.</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9.29.1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Road Department (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Thomas Beall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Whitey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>                    </u>		17. INFORMANT <u>Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy, decumbency</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO (c) <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>          </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>	
20f. (City or town) <u>                    </u>				(County) <u>                    </u>		(State) <u>                    </u>	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>59</u> , to <u>8/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>8.28.59</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>                    </u>				PHYSICIAN'S NAME (Type) <u>A. D. Bonifant, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial Aug 31, 1959</u>		<u>                    </u>		<u>Union Cemetery</u>		<u>Burtonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canaleham</u>				ADDRESS <u>                    </u>		24a. REC'D BY REGISTRAR <u>                    </u>	
24b. REGISTRAR'S SIGNATURE <u>                    </u>				DATE <u>SEP 2 '59</u>		<u>                    </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9243

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09184

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		d. STREET ADDRESS <b>215 Northway Giddens</b>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Elizabeth</b> Last <b>Beck</b>		4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1.20.1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Luther Scott Clagett</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ryan Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy, Thrombotic</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis</b> DUE TO (c) <b>Chronic myocarditis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>55</b> , to <b>8/18</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/18</b> , 19 <b>55</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>8/18/59</b>			
ACTUAL SIGNATURE <b>A. D. Bonifant, M. D.</b>		M. D. <b>Sandy Spring, Md.</b>	
PHYSICIAN'S NAME (Type)		8.18.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	22b. DATE THEREOF <b>8/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Maus.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Lockner &amp; Sons - Baltimore</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

9244

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

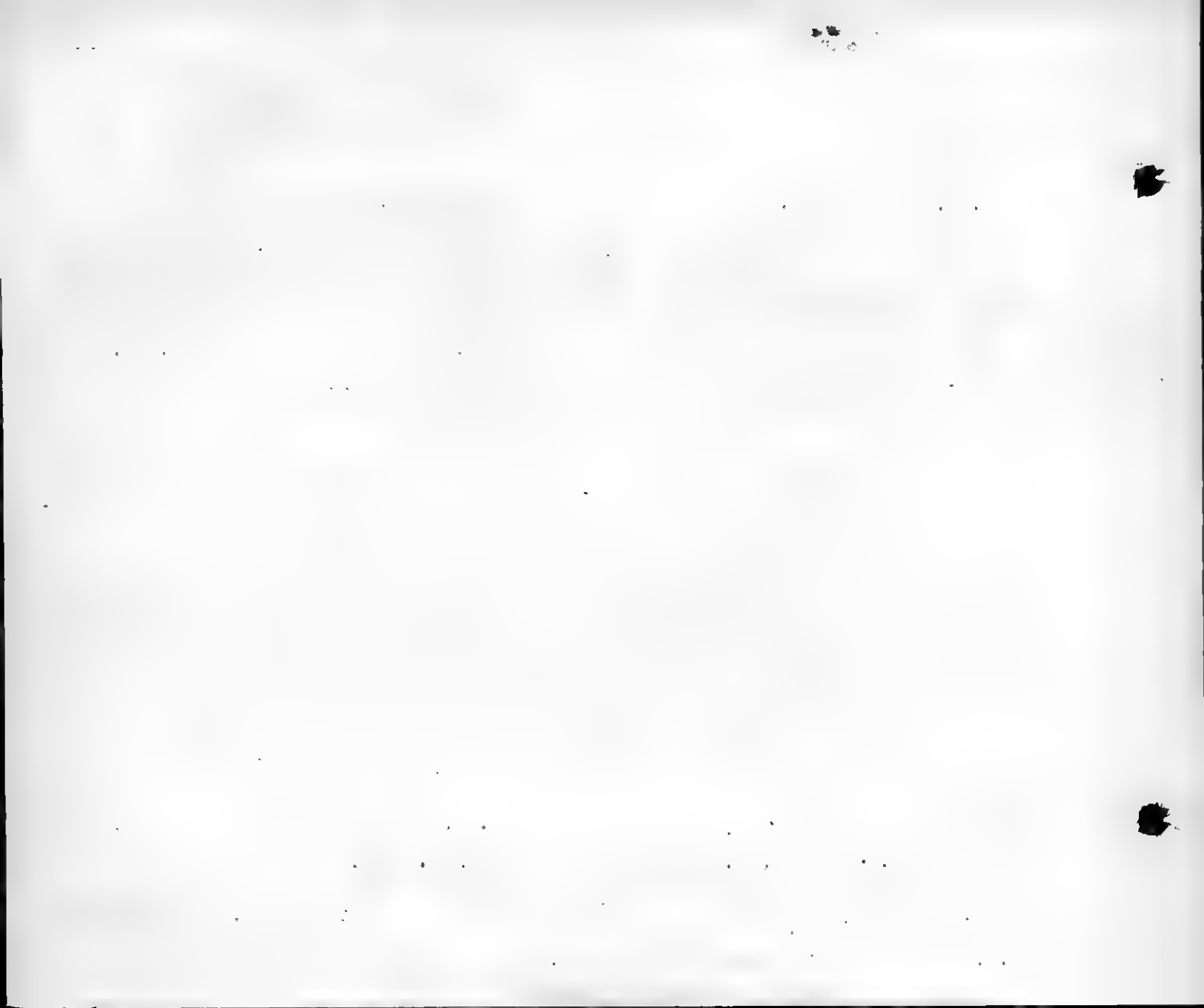
CERTIFICATE OF DEATH

Reg. Dist. No.

09185  
215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>7105 CLARENDON ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kevin Wayne BENNETT</b>		4. DATE OF DEATH Month Day Year <b>August 9 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-59</b>
9. AGE (In years last birthday) yrs <b>8</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Buddy Lee BENNETT</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ruth JONES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis acute</b> 340.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1</b> , 19 <b>59</b> , to <b>August 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 9</b> , 19 <b>59</b> , and that death occurred at <b>8:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b> DATE SIGNED <b>8-10-59</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>U. S. Naval Hospital</b> PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b> <b>Bethesda, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>8-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Butler, Mo. MISSOURI</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b> R.A. Humphrey Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

2051221XV3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

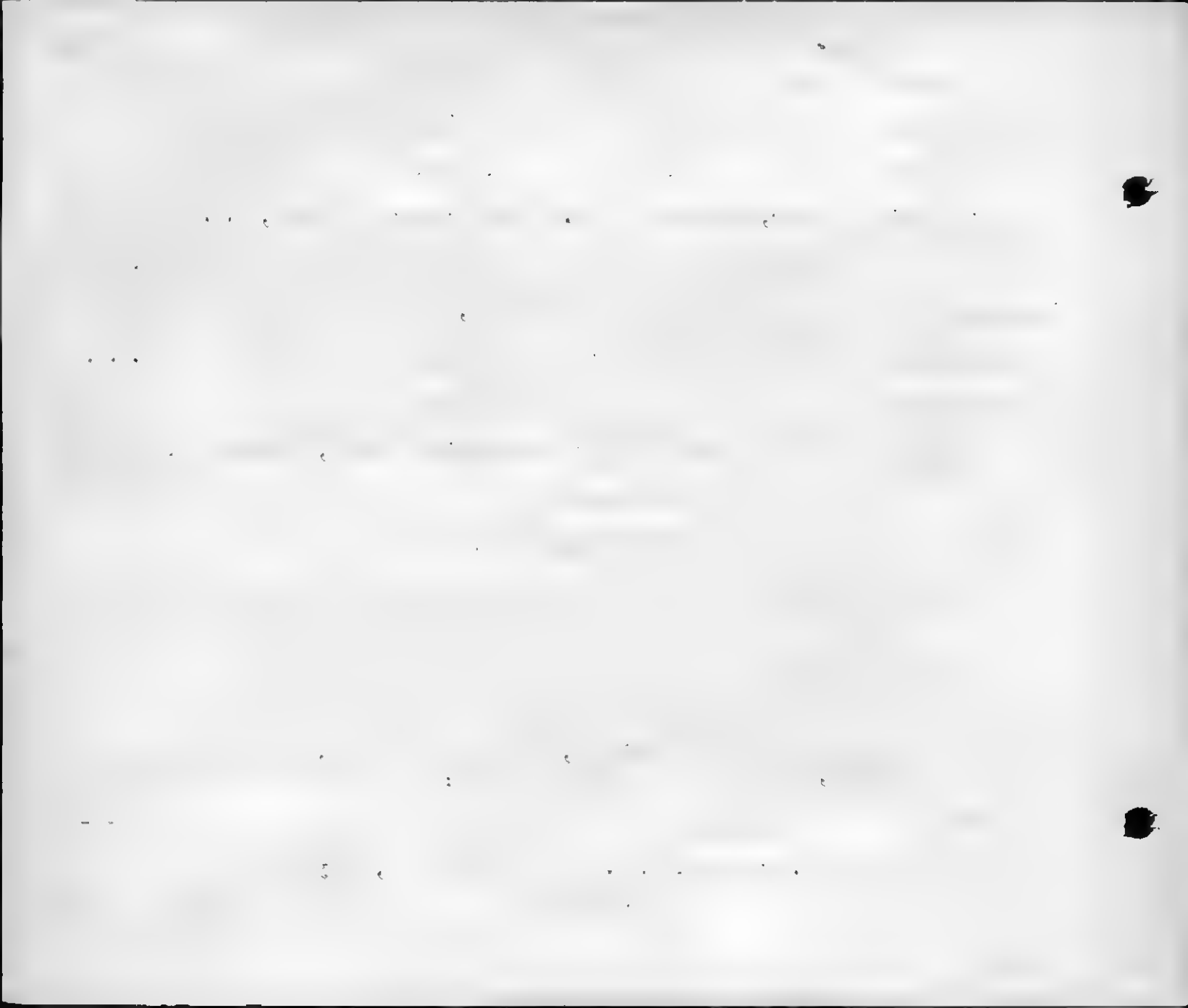
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9245- CERTIFICATE OF DEATH

09186

Reg. Dist. No.

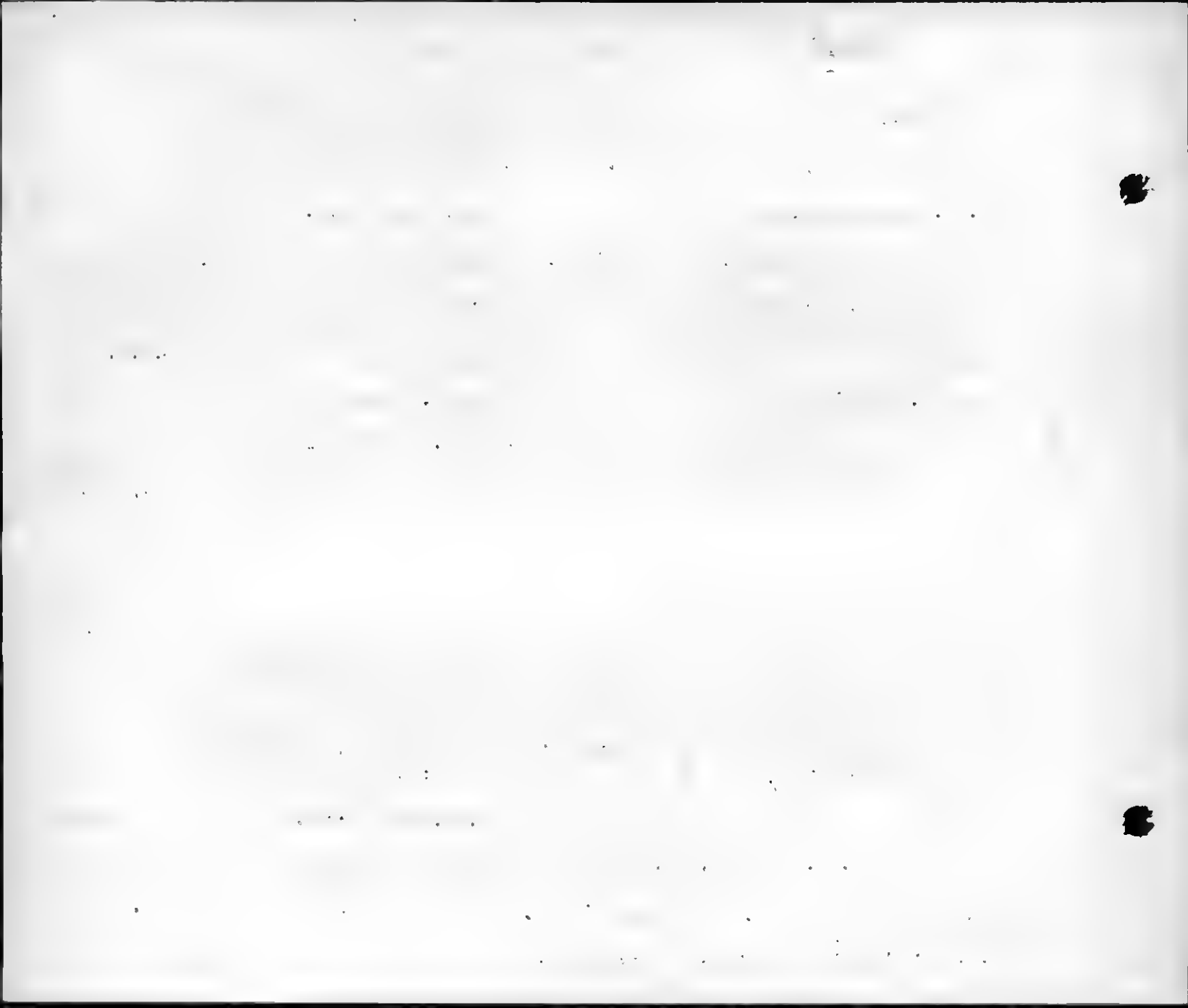
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN It <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Willis</b> Middle <b>Stokes</b> Last <b>Booth</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3, 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Streetcar motorman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward Booth</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Cellie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>Unascertainable</b>				16. SOCIAL SECURITY NO. <b>577-20-1408</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Larynx</b> DUE TO (c) <b>1 year</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 28, 1959</b> to <b>August 9, 1959</b> , that I last saw the deceased alive on <b>August 9, 1959</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Howard S. Schwartz</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-9-59</b>			
PHYSICIAN'S NAME (Type) <b>Howard S. Schwartz, M. D.</b>				ADDRESS <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b> ADDRESS <b>517 11th St. S.E.</b>				24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
9246										
CERTIFICATE OF DEATH										
Reg. Dist. No. 215										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>East Point</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>41X</b> d. STREET ADDRESS <b>1395 Virginia Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Phillip BOYNTON</b>					4. DATE OF DEATH Month Day Year <b>August 11 19 59</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-58</b>		9. AGE (In years last birthday) <b>1 yrs</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Jack D. BOYNTON</b>					14. MOTHER'S MAIDEN NAME <b>Faye S. CRUSE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(F) Jack D. Boynton, same as #2 above</b>					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atrio-ventricular canal</b> <b>1540</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> INTERVAL BETWEEN ONSET AND DEATH <b>from birth</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>August 10</b> , 19 <b>59</b> , to <b>August 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 11</b> , 19 <b>59</b> , and that death occurred at <b>5:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-12-59</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>U. S. Naval Hospital</b> PHYSICIAN'S NAME (Type) <b>G. I. SMUGOLL, LT, MC, USN</b> <b>Bethesda, Maryland</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>8-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>College Park Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>College Park Georgia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b> ADDRESS <b>R.A. Humphrey Funeral Home, Bethesda, Md.</b>					24a. REC'D BY REGISTRAR <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

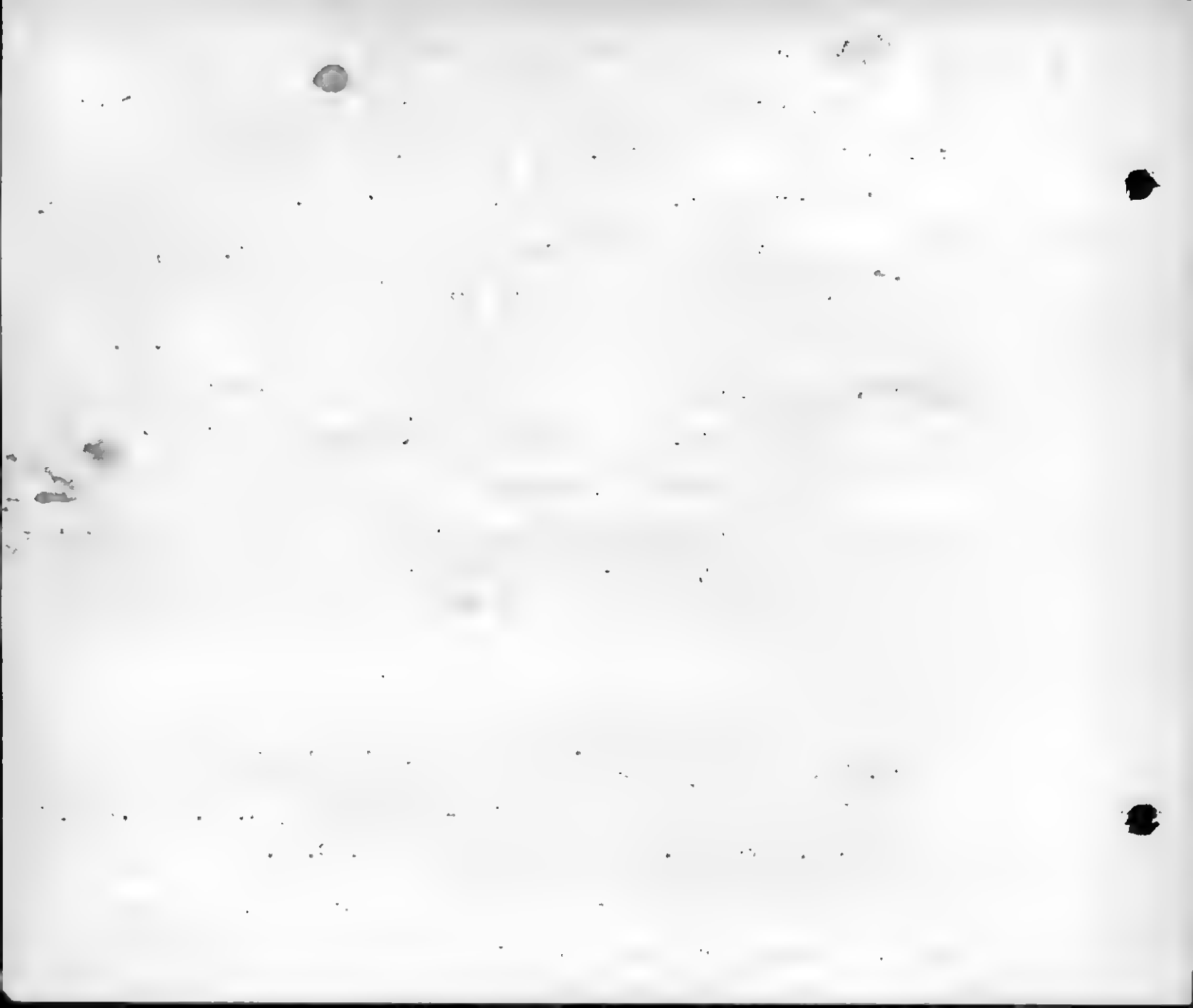
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9247

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>7514 Radnor Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7514 Radnor Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>MAY</b> Last <b>BRADFORD</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>28,</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1867</b>
9 AGE (In years last birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>27</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Alabama</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>John W. Comalander</b>	
14. MOTHER'S MAIDEN NAME <b>Jamaima Cortez</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Son.</b> <b>ROBERT BRADFORD</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Rheumatic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 14, 1959</b> to <b>Aug. 28, 1959</b> , that I last saw the deceased alive on <b>Aug. 26, 1959</b> , and that death occurred at <b>7:00A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>JACK P. SEGAL, MD.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>900-17th Street, N. W. 8-28-59</b> <b>Washington, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-31-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





9248

## CERTIFICATE OF DEATH

09189

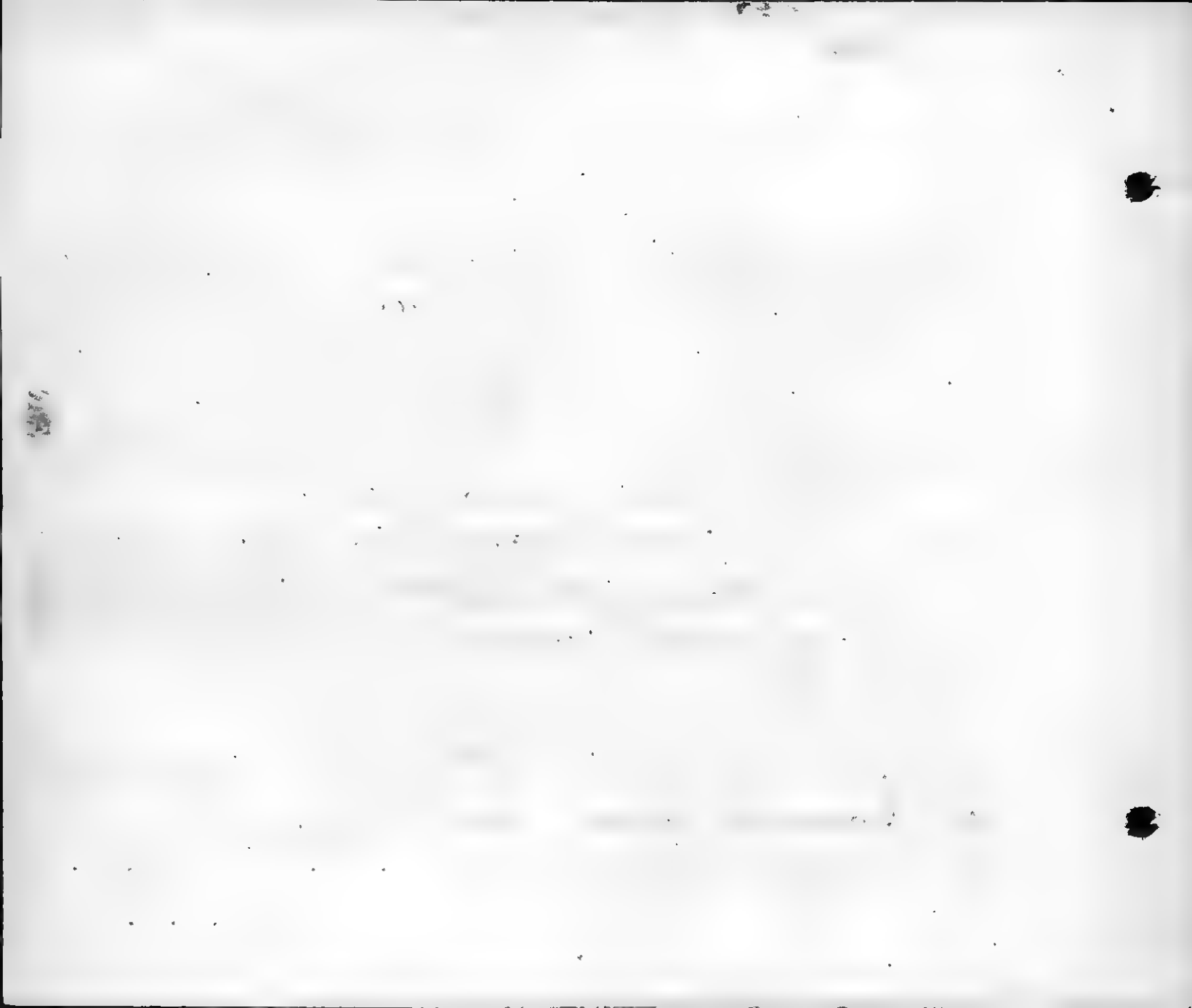
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hosp</u>		d. STREET ADDRESS <u>5637 Western Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Young BRADY</u>		4. DATE OF DEATH Month Day Year <u>Aug 14 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1889</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Architectural</u>	
11. BIRTHPLACE (State or foreign country) <u>FRANKLIN, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES BRADY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET M YOUNG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Louise BRADY - (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory/Circulatory Failure.</u> DUE TO (b) <u>Cerebral Vascular Accident.</u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia - Basilar</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/27</u> , 19 <u>59</u> , to <u>8/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Q Elsmen</u> M.D.		ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave. Chevy Chase, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Donald Q Elsmen</u>		DATE SIGNED <u>8/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphery</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09190

9249

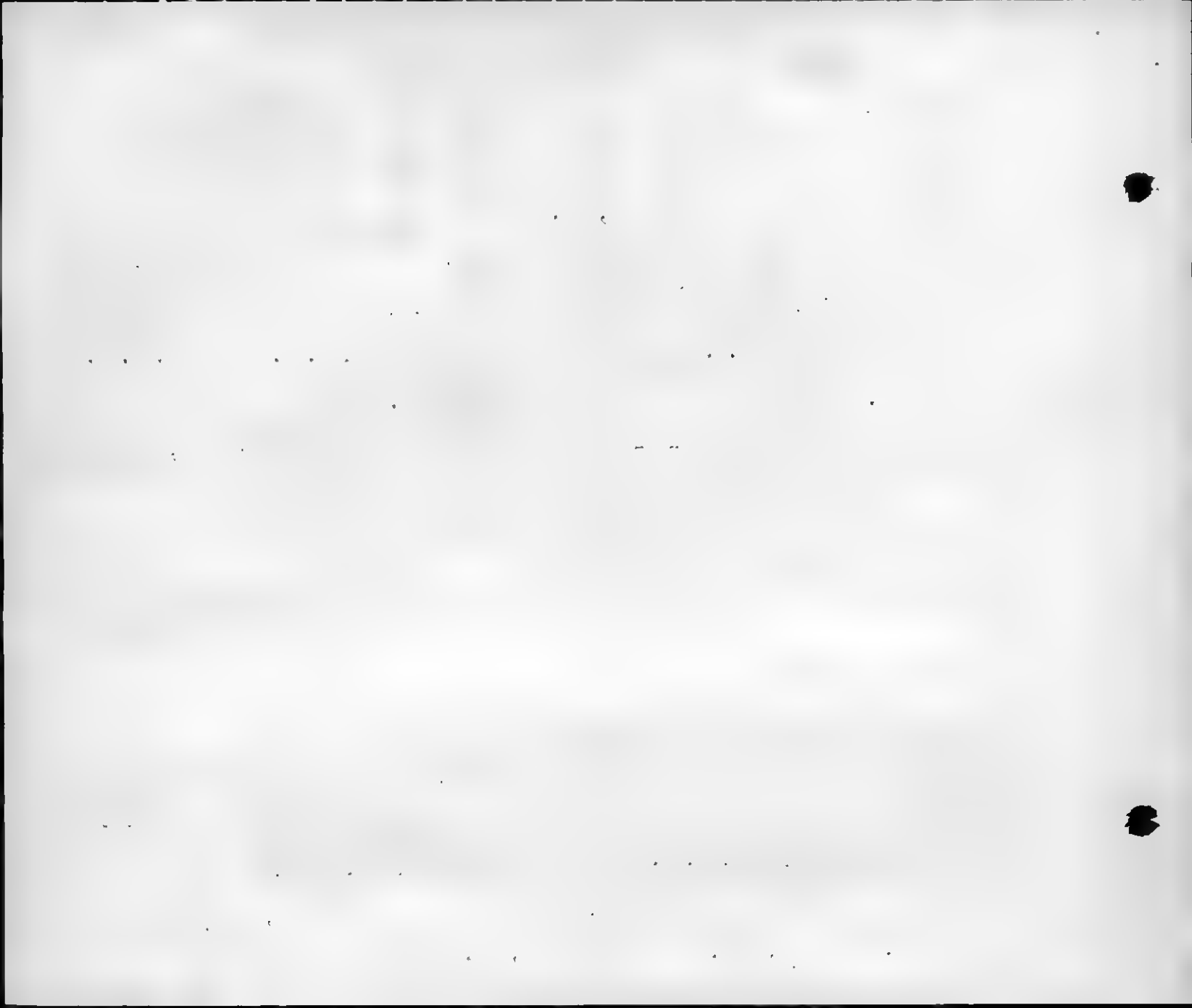
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>3303 Fayette Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Lambert Brown</b>		4. DATE OF DEATH Month Day Year <b>August 1, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1904</b> 9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Drug Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles L. Brown</b>		14. MOTHER'S MAIDEN NAME <b>ERMA IRMA L. Gaither</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-07-6317</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia secondary to</i> DUE TO <i>varicella</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis of the liver</i> DUE TO (c) <i>chronic myeloid</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30, 19 59</b> to <b>August 1, 19 59</b> , that I last saw the deceased alive on <b>August 1, 19 59</b> , and that death occurred at <b>8:05 P</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 8-2-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <i>Alfred Leitner</i> M.D.		PHYSICIAN'S NAME (Type) <b>Alfred Leitner, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>IVY HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>UPPERVILLE, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <i>Raymond E. A. Z...</i>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>ADG 4</b> DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

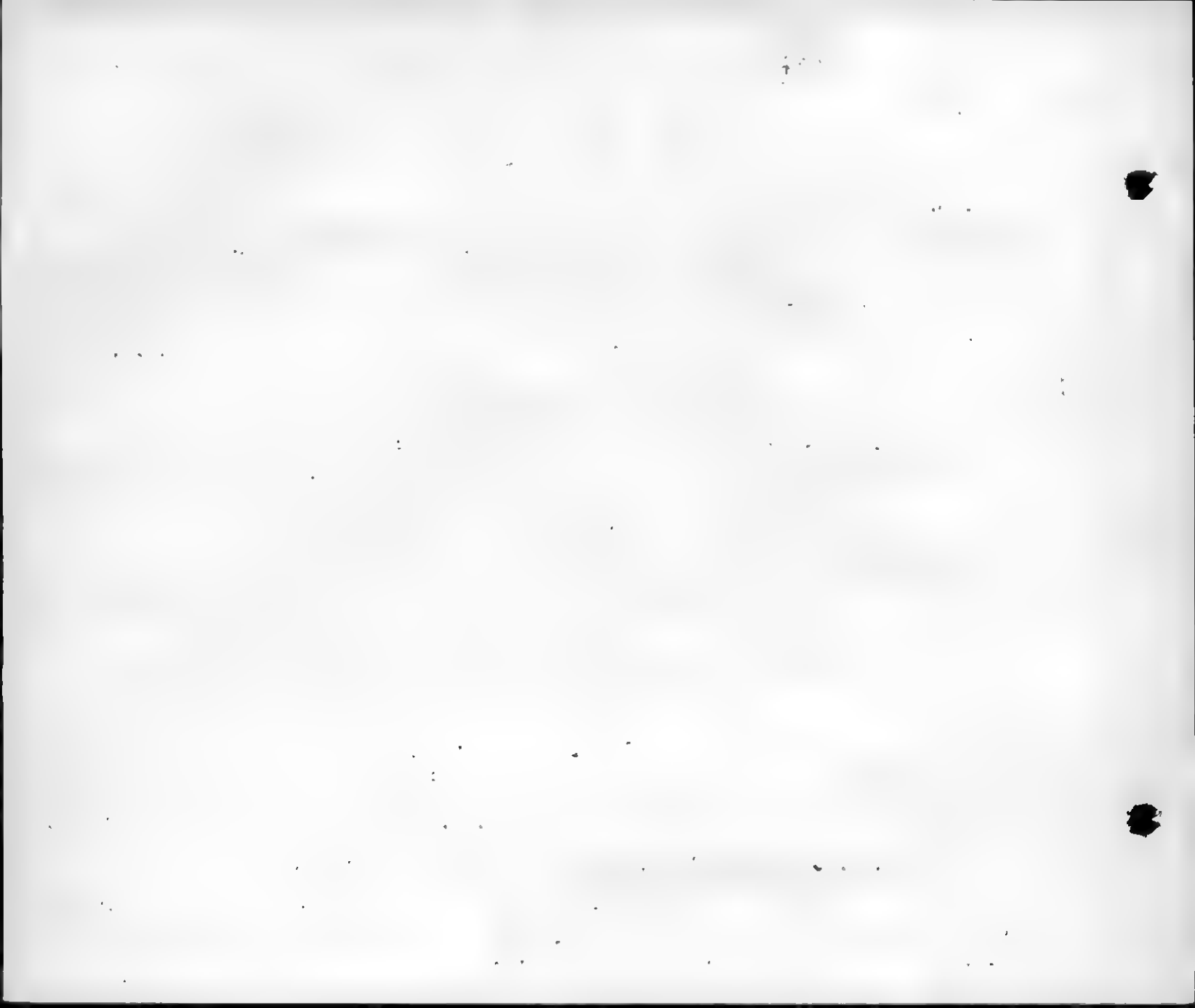
## 9250

### CERTIFICATE OF DEATH

09191

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Missouri</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mexico</b> d. STREET ADDRESS <b>RFD #4</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leslie Holmer BULL</b>			4. DATE DEATH Month Day Year <b>August 22 19 59</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-96</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John BULL</b>			14. MOTHER'S MAIDEN NAME <b>Nellie DEBO</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>5/17 to 9/19 Unknown</b>		INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO <b>Myocardial Infarct</b> <b>Coronary occlusion</b> <b>Coronary Atherosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Seconds?</b> <b>3 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27</b> , 19 <b>59</b> , to <b>August 22</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>6:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7 H. C. Connell</b> M.D. <b>U. S. Naval Hospital</b> <b>8-22-59</b>					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LCDR, MC, USN Bethesda, Maryland</b>					
22a. BURIAL, CREMATION, REMOVA, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Funeral Home, 1400 Chapin St. NW</b>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

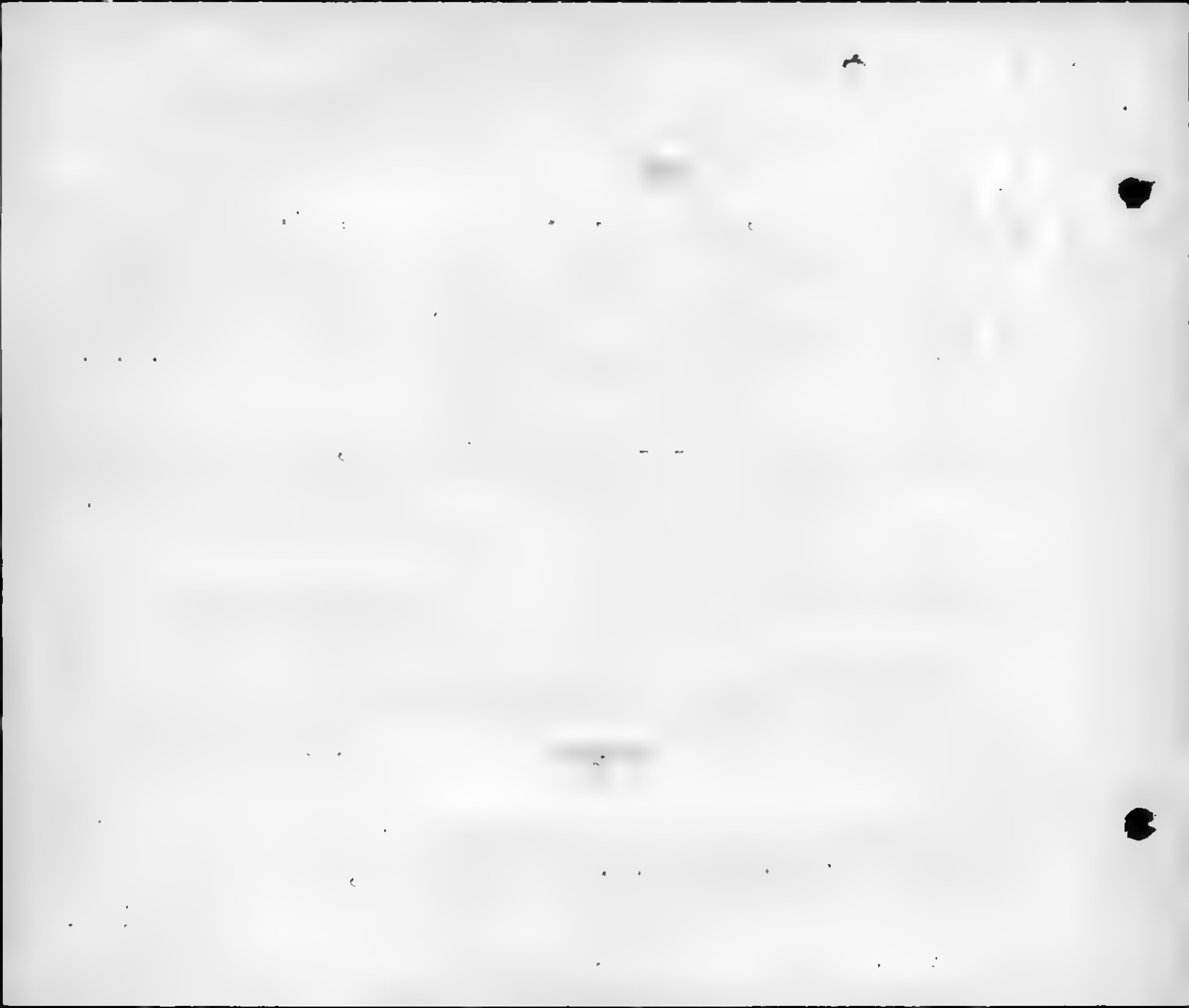
9251

## CERTIFICATE OF DEATH

Reg. Dist. No.

09192

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>97 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>714 Manor Road, Apt. # 303</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanor Josephine Burke</b>		First Middle Last		4. DATE OF DEATH <b>August 30 1959</b>		Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1927</b>		9. AGE (In years last birthday) <b>32</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Press Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Steve Yenko</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Koss</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>206-22-1718</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cryptococcosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>1 month</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)		20j. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 May 1959</b> to <b>30 August 1959</b> , that I last saw the deceased alive on <b>30 August 1959</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>8/31/59</b>		ACTUAL SIGNATURE <b>Harold J. Fallon</b> M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>9/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Lourdes</b>		22d. LOCATION (City, town, or county) (State) <b>Robinson Township, Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09193

Reg. Dist. No.

9252

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wayfield Rd</u>				d. STREET ADDRESS <u>Wayfield Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Albert James Butler</u>				4. DATE OF DEATH <u>Aug 9 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-1908</u>	
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>		IF UNDER 24 HRS Hours <u>9</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Butler</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Beul Brather</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hilda Butler (wife)</u> Address <u>Stim 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left lung with</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis</u> DUE TO (c) <u></u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blaschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Blaschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMAINS (Type) <u>Burial</u>		22b. DATE THEREOF <u>8/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove,</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Sworde</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 '59</u> DATE	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



9253

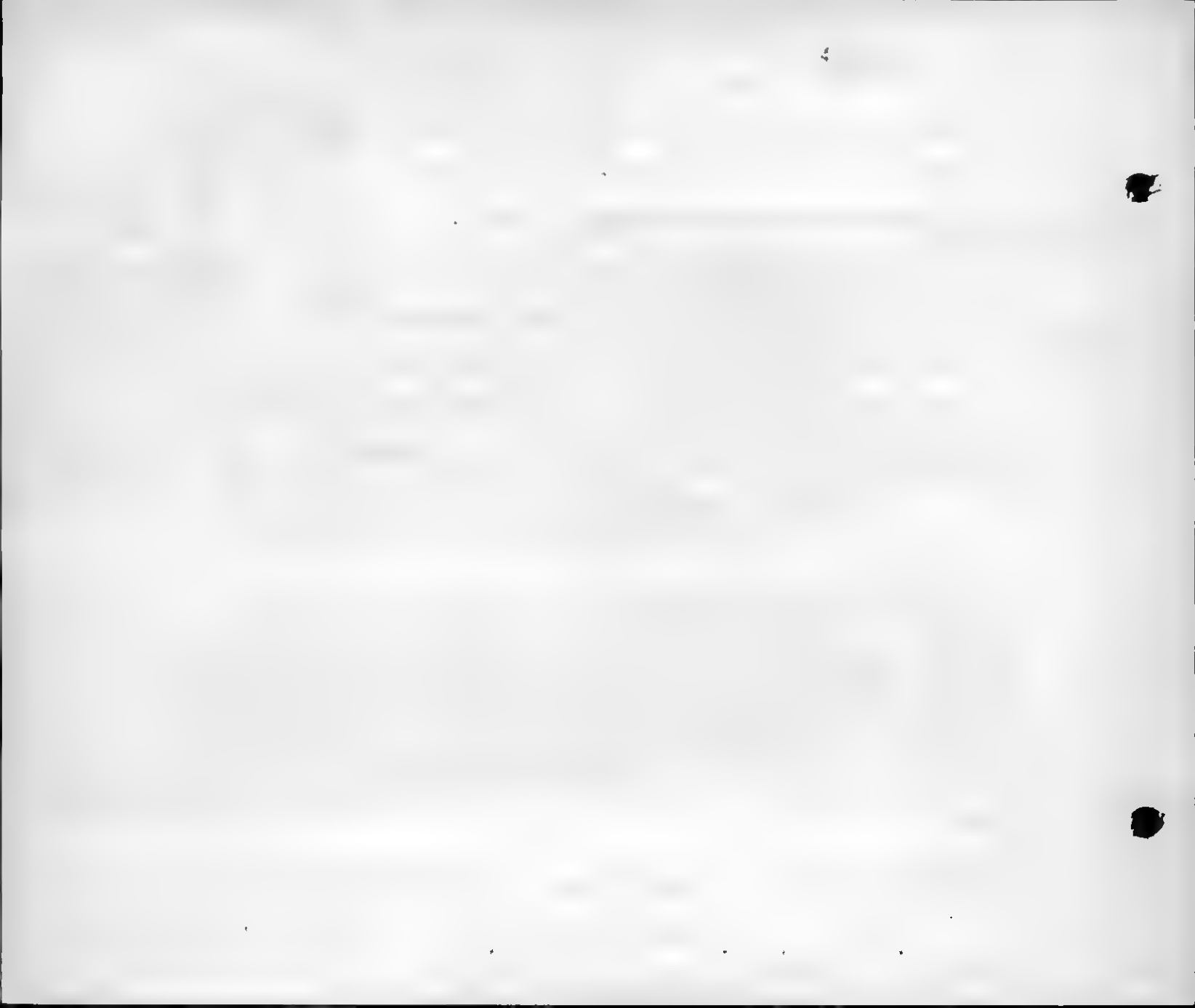
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Lee Butt</b>				4. DATE OF DEATH Month Day Year <b>August 3 19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/13/90</b>		9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private nursing care</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Edwin Shaw</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Virginia Sullivan</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>577-01-9250</b>				17. INFORMANT Address <b>Hospital Records Olney, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b> DUE TO <b>Adenocarcinoma of Cervix Uteri</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yrs.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 59</b> , to <b>8/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/2</b> , 19 <b>59</b> , and that death occurred at <b>1:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>C. H. Ligon</b>				M.D. <b>Sandy Spring, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M. D.</b>				22a. NAME OF CEMETERY OR CREMATORY <b>Colesville Cemetery</b>			
22b. DATE THEREOF <b>8/6/59</b>				22c. LOCATION (City, town, or county) (State) <b>Colesville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc., Silver Spring, Md.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9254

## CERTIFICATE OF DEATH

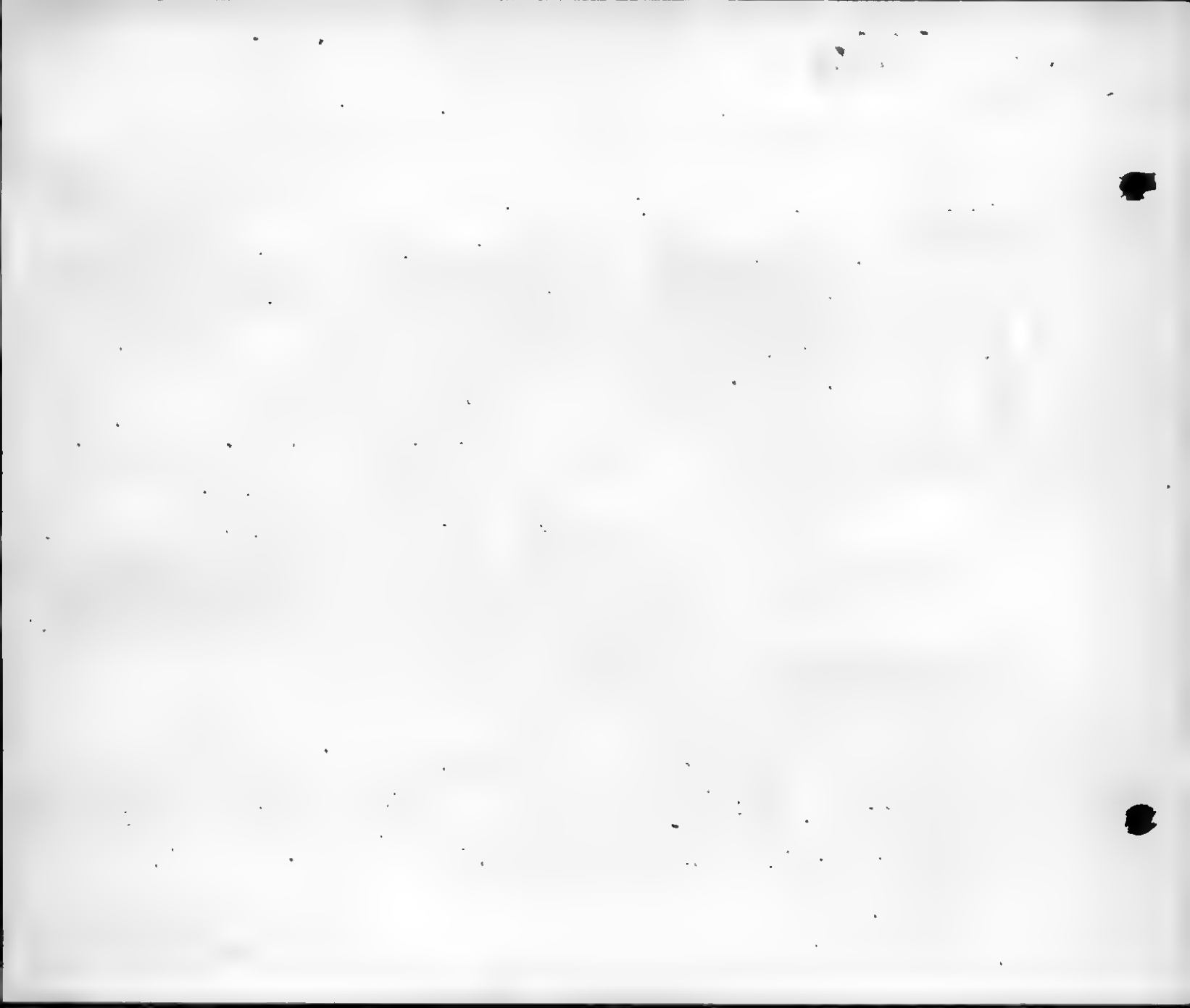
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>New York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW YORK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8800 MELWOOD ROAD</b>		d. STREET ADDRESS <b>124 W. 47TH ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>PAUL</b> Last <b>CARROLL</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 9, 1895</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>14</b> Min.	11. IF UNDER 24 HRS Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLIC RELATIONS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ENTERTAINMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>EIRE</b>		12. CITIZEN OF WHAT COUNTRY? <b>EIRE</b>	
13. FATHER'S NAME <b>JOHN CARROLL</b>		14. MOTHER'S MAIDEN NAME <b>ANNE WELCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>077-01-2340</b>	
17. INFORMANT <b>LA. PYLE, JR. MD</b>		Address <b>8800 MELWOOD RD BETHESDA 14, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure (obstructive)</b> 1-21 DUE TO <b>Bronchogenic carcinoma (at least)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 months</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1959</b> to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-13-59</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Margaret Foret M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>1746 K St. N.W.</b> DATE SIGNED <b>8/13/59</b>	
PHYSICIAN'S NAME (Type) <b>MARCEL J FORET</b>		<b>Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Md</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

9205

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

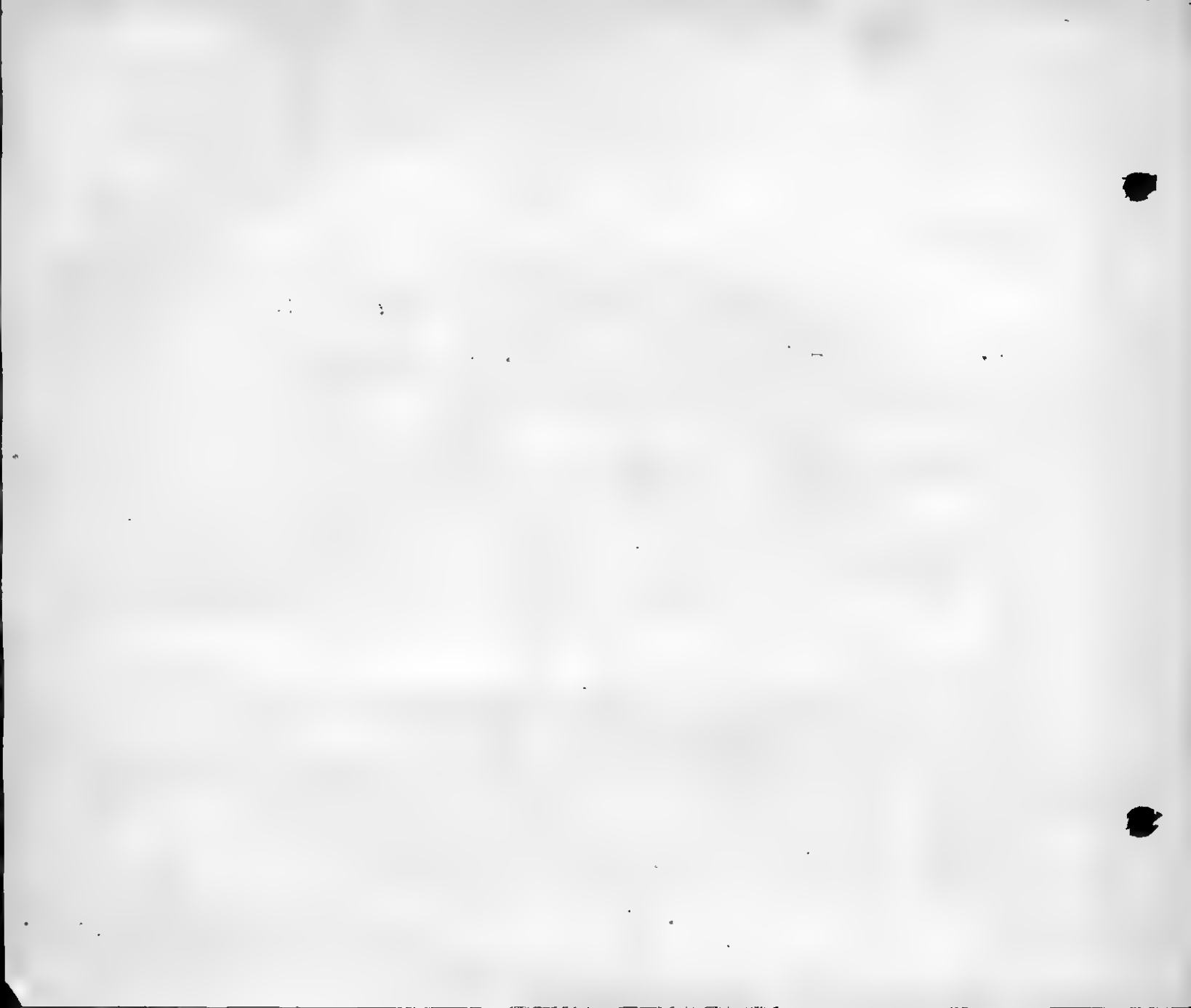
Reg. Dist. No.

09196

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>7 1/2 hrs</u>		d. STREET ADDRESS <u>8500 11th Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Anna Charukas</u>	4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-29</u>
9. AGE (In years last birthday) <u>30</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive Firestone &amp; Rubber Co. Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Manuel J. Charukas</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u>			
DUE TO (b) <u>Fracture of skull</u>			
DUE TO (c) <u>Struck by auto</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pedestrian crossing street</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Struck by auto while crossing street</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:31 p.m. 8-15-1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>727 W. Blvd E</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Kinsco</u>		24a. REC'D BY REGISTRAR <u>29101-14th St. N.W. Wash. D.C.</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

9255

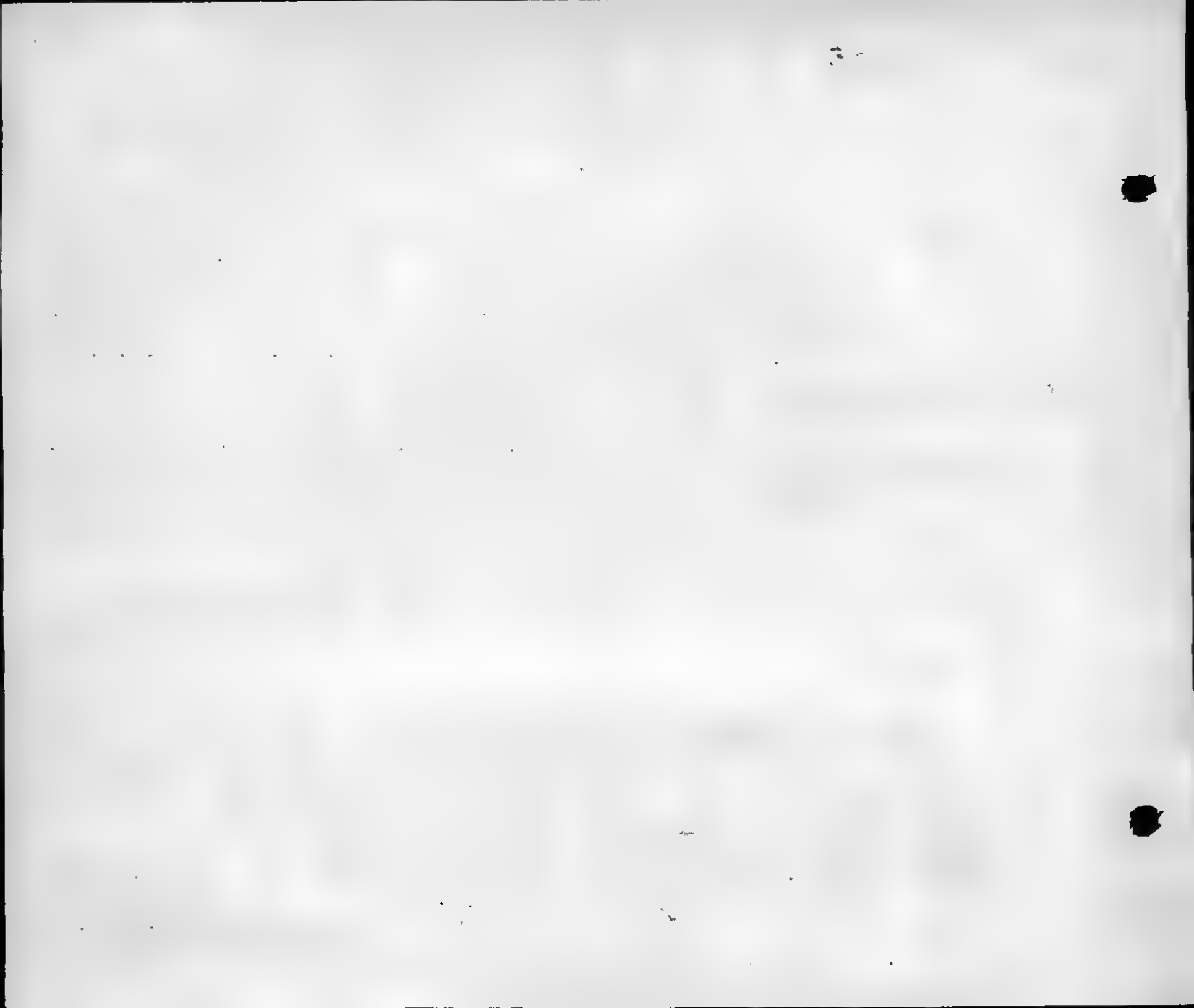
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>1 yr.</b>		d. STREET ADDRESS <b>6923 Clarendon Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6923 Clarendon Road</b>			
3. NAME OF DECEASED (Type or print) First <b>NEWELL</b> Middle <b>D.</b> Last <b>CHASE</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>10,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1871</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Engr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hanibal Chase</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Newell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nina R. Chase, 6923 Clarendon Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 450. DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Aricular fibrillation</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clifford S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

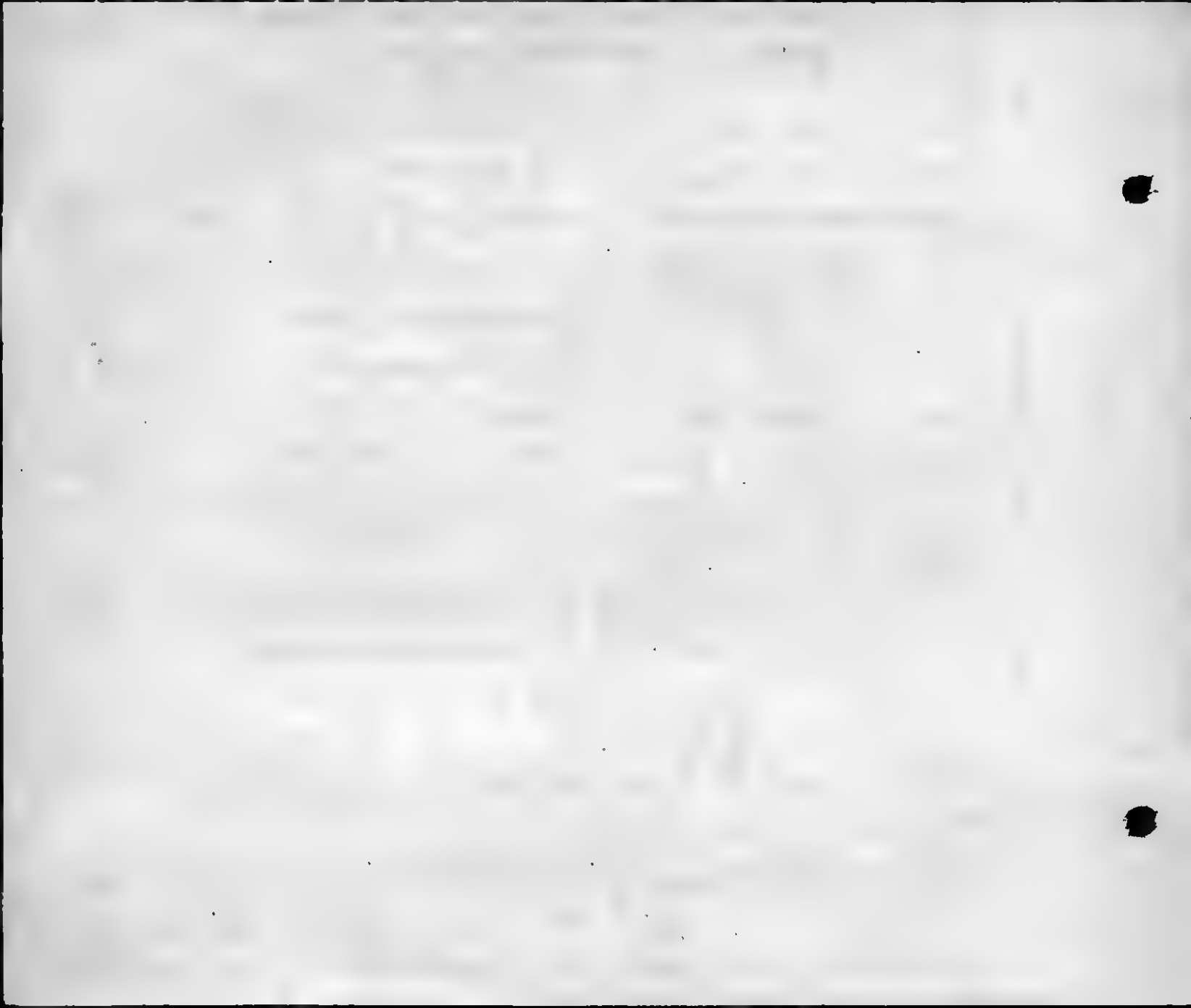
09198

92

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>812 Grandin Avenue</b>		d. STREET ADDRESS <b>812 Grandin Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>GRACE COLLONS CLAGETT</b>		4. DATE OF DEATH <b>Aug. 11, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/13</b>
9. AGE (in years last birthday) <b>45 yrs</b>		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Potomac, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Collins</b>		14. MOTHER'S MAIDEN NAME <b>Eliz. Clagett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter - Rose L. Clagett</b>		Address <b>812 Grandin Avenue Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism Due Thrombophlebitis</b> DUE TO <b>Right Leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral Infection</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 weeks</b> <b>30 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 49</b> , 19, to <b>Aug 1959</b> , that I last saw the deceased alive on <b>10 Aug 1959</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.S. Murphy</b>		DATE SIGNED <b>6/15/60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. S. Murphy</b>		ADDRESS <b>615 W. Montgomery Ave., Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lyon Walker</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9256

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>88 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Roach</b> Last <b>Clarke</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1915</b>		9. AGE (In years last birthday) <b>44</b> yns.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of Concrete Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Concrete</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Garland Clarke</b>				14. MOTHER'S MAIDEN NAME <b>Celeste Roach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-05-5734</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> <b>2043</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myelocytic leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>1 year</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral hemorrhage</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3</b> , 19 <b>59</b> , to <b>August 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 30</b> , 19 <b>59</b> , and that death occurred at <b>2:15 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/30/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <i>Jerry S. Trier</i>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b>		M.D. <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/ 2/ 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 4 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Celia L. Hunt</i>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

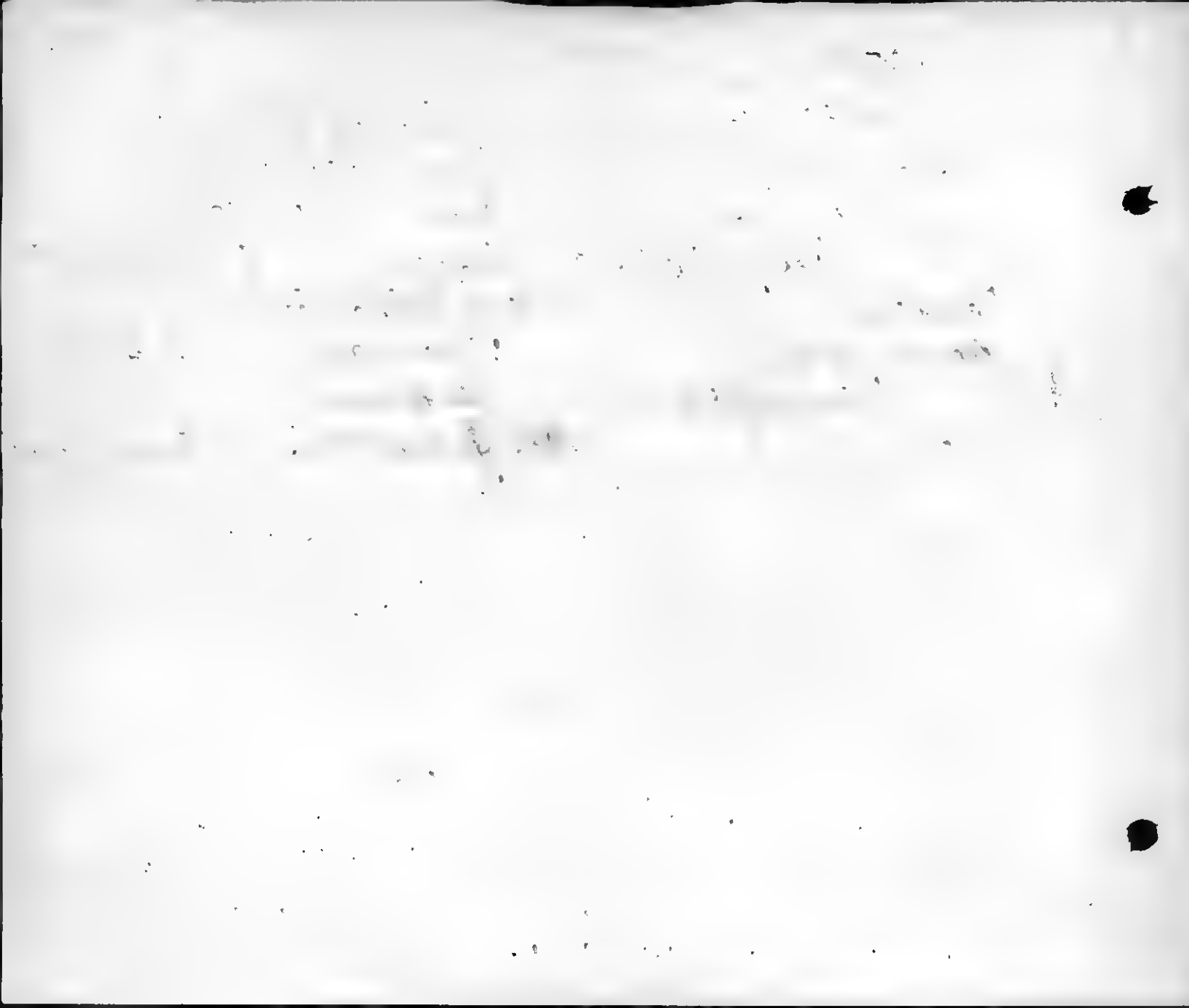
09200

9257

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Greenbelt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Route 2 Box 110</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Virginia</u> Last <u>Clipper</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Mrs Gerline Ellis Same - daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO (b) <u>Diabetes mellitus &amp; Acidosis</u> DUE TO (c) <u>Arteriosclerotic Cardio-vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular Accident</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:45</u> A.M. from the causes and on the date stated above.	
22a. ADDRESS (Street, city or town, state) <u>26 N. Semant Ave. Greenbelt, Md.</u>		DATE SIGNED <u>Aug 11 1959</u>	
ACTUAL SIGNATURE <u>Gordon R. Rosenberg</u> M.D.		PHYSICIAN'S NAME (Type) <u>Gordon Rosenberg M.D.</u>	
22a. BLR AL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Seneca</u>	22d. LOCATION (City, town, or county) (State) <u>Seneca, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surwden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9258

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7721 Eastern Ave</u>		e. STREET ADDRESS <u>7721 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lloyd Phillip Coblentz</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-06</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>delivery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pickens X-ray</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Joseph D. Coblentz</u>		14. MOTHER'S MAIDEN NAME <u>Lillian B. Shalkop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW #2</u>		16. SOCIAL SECURITY NO. <u>578-24-4921</u>	
17. INFORMANT <u>Mrs. Lillian J. Poole, 111 Wayne Place, S.E.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DAUG 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

DATE SIGNED

8-25-59



9259

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09202

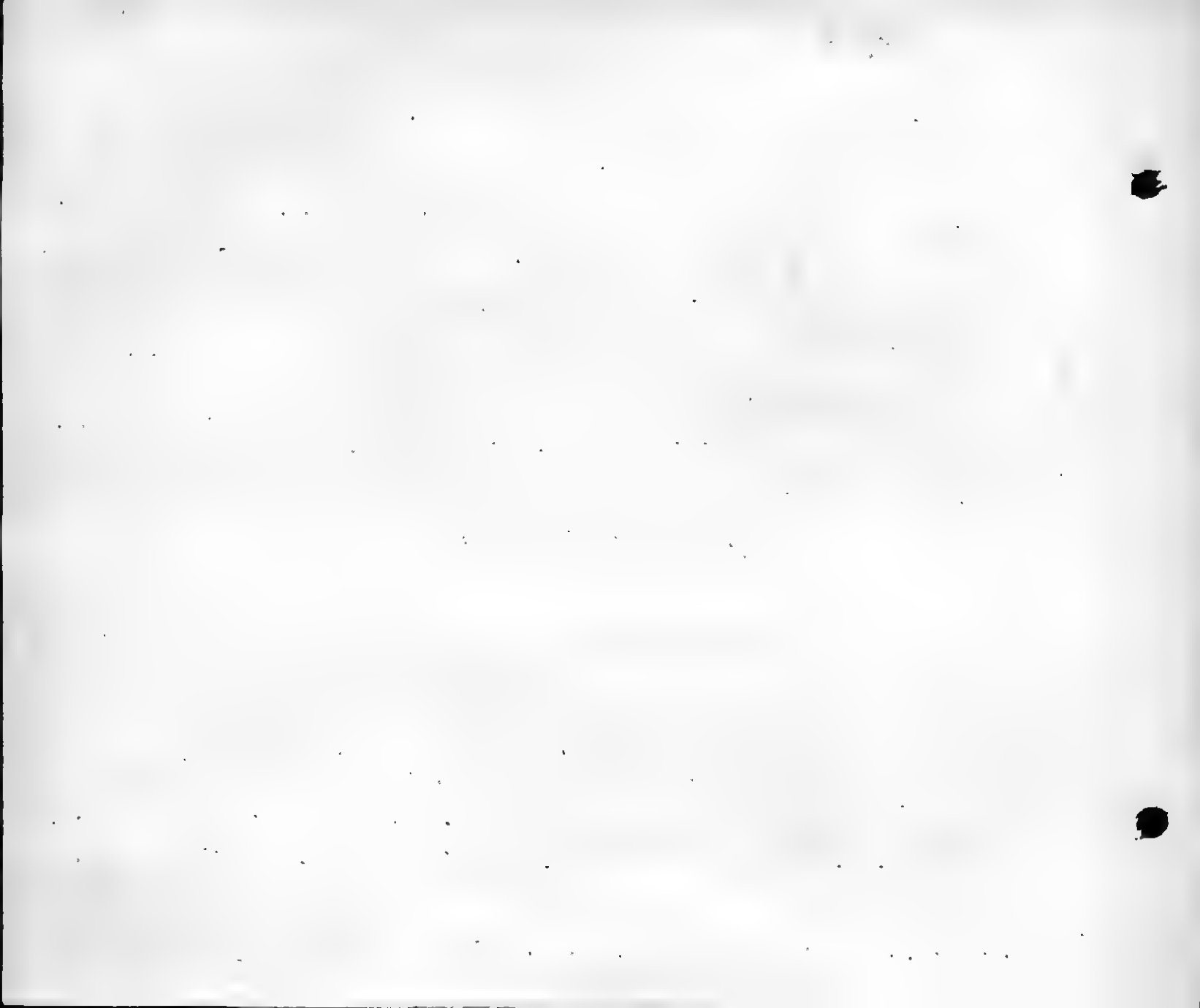
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>		e. STREET ADDRESS <b>2500 Q. Street N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>M ARIE</b> Middle <b>T.</b> Last <b>COFFIN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>18</b> Year <b>19 59</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5/6/92</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>MARSHALL THRAILKILL</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA HAUGHN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		INFORMANT <b>MR. Thad Brown (Son) 3045 Chain Bridge Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Gall Bladder</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3 Aug</b> , 19 <b>59</b> , to <b>18 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 Aug</b> , 19 <b>59</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>615 MONTGOMERY AVE., ROCKVILLE, MD.</b> DATE SIGNED <b>W. S. MURPHY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>
22d. LOCATION (City, town, or county) <b>Columbus,</b>		(State) <b>Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler Jr.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 21 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9260

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

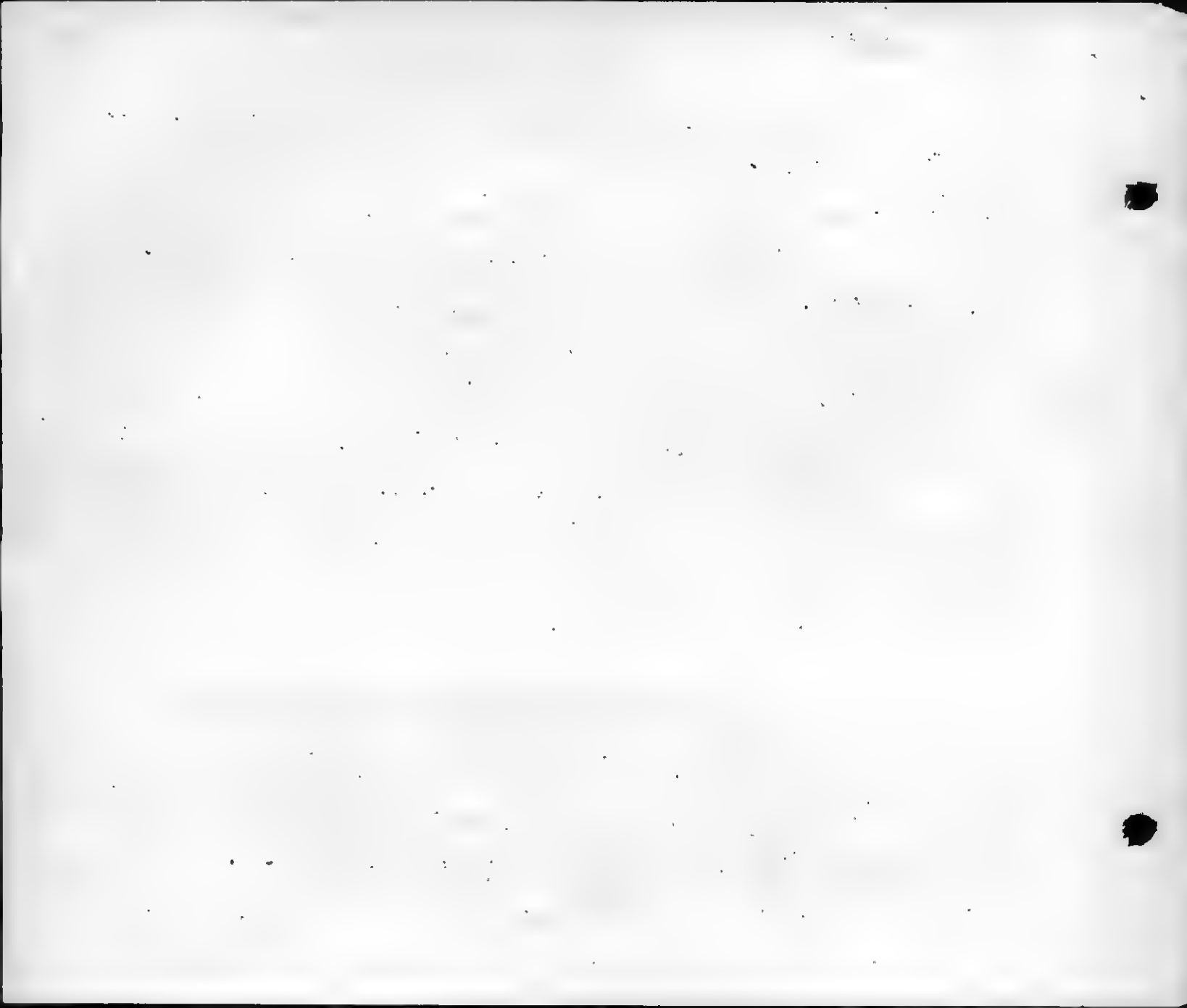
00203

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1 Falls Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM R COLLINS</u>		4. DATE OF DEATH Month Day Year <u>Aug 25 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Franklin R. Collins</u>		14. MOTHER'S MAIDEN NAME <u>Harriette Houser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>David R. Collins</u>		Address <u>Arlington 3419 N. ARLINGDON DR</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Abdominal Aneurysm</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of aorta</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Myocardial Infarction</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25</u> , 19 <u>59</u> , to <u>Aug 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>59</u> , and that death occurred at <u>12</u> M from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. C. Waganzini</u>		M.D. <u>809 Viers Mill Rd</u>	
PHYSICIAN'S NAME (Type) <u>H. C. Waganzini</u>		ADDRESS (Street, city or town, state) <u>Rochester Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>AUG 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. 115 (4)  
 15M 9/55

9261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

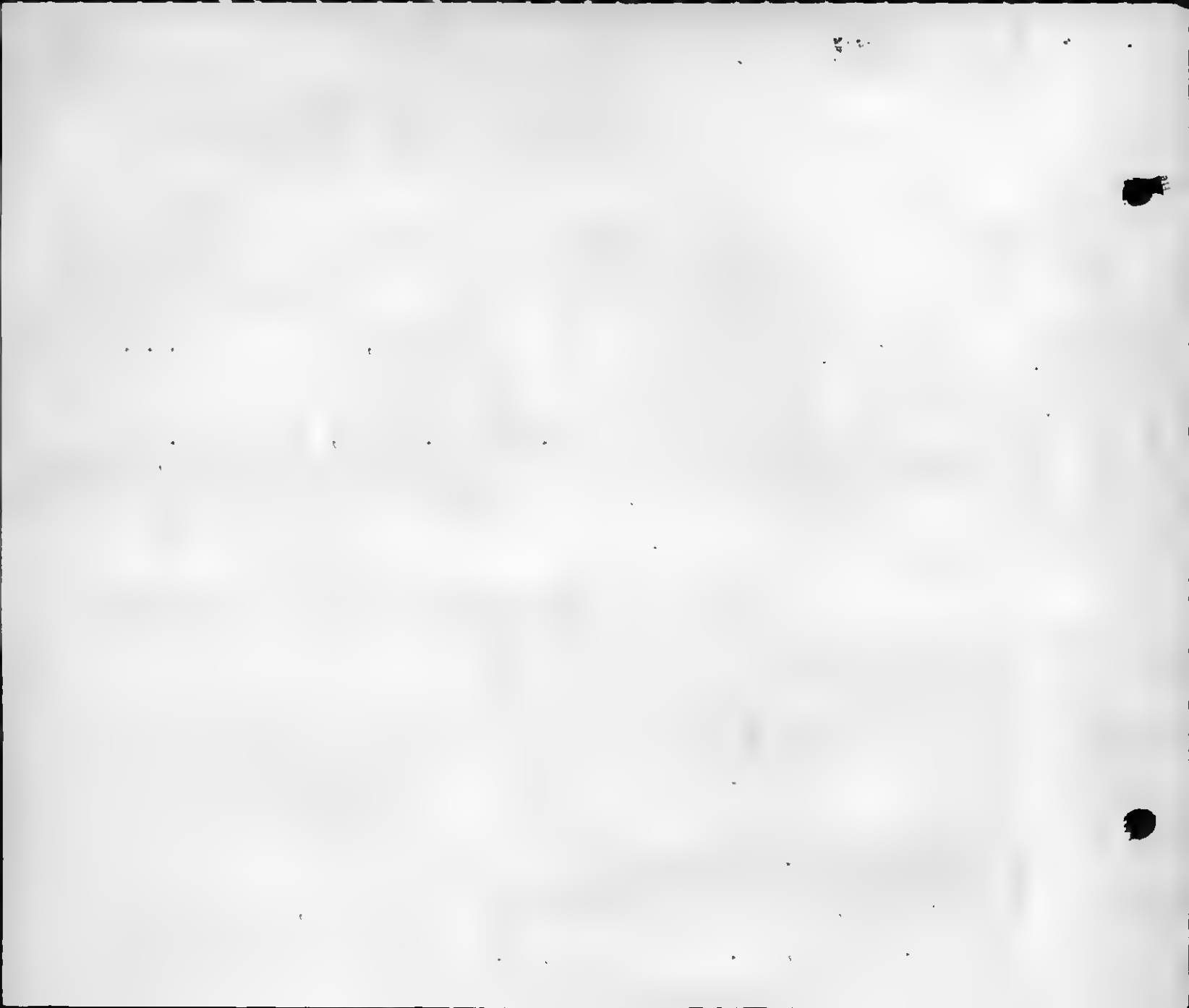
CERTIFICATE OF DEATH

Reg. Dist. No.

05204

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAPLE LANE NURSING HOME</b>		d. STREET ADDRESS <b>902 HERON DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Josephine</b> Last <b>CONROY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/77</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>TUAM COUNTY, IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS LOFTUS</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Martin J. Conroy, 902 Heron Dr., Silver Spring, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSION</b> DUE TO <b>PLAQUE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DISSEMINATED</b> DUE TO <b>HYPERENSION</b> (c) <b>GENERALIZED</b> DUE TO <b>ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SEMI-ILL</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 22</b> , 19 <b>55</b> , to <b>Aug. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 17</b> , 19 <b>59</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D. <b>1959</b> PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MADONNA CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FORT LEE, NEW JERSEY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

MEDICAL CERTIFICATION





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09205

9262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9704 ADMIRALTY DRIVE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>9704 Admiralty Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WINIFRED</b> Middle <b>M.S.</b> Last <b>COOKSON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>1959</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/76</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>19</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maine</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>---Stone</b>		14. MOTHER'S MAIDEN NAME <b>---Harper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Ione Slothower</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, uterine &amp; metastases</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 mo.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>20b</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> to <b>Aug 16, 1959</b> , that I last saw the deceased alive on <b>Aug 15, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10111 COLESVILLE RD</b> DATE SIGNED <b>10/11/59</b>			
ACTUAL SIGNATURE <b>A. F. Thibadeau</b>		M.D. <b>10/11/59</b>	
PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b>		<b>SILVER SPRING, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>8/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>
24c. DATE <b>AUG 18 '59</b>			

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9263

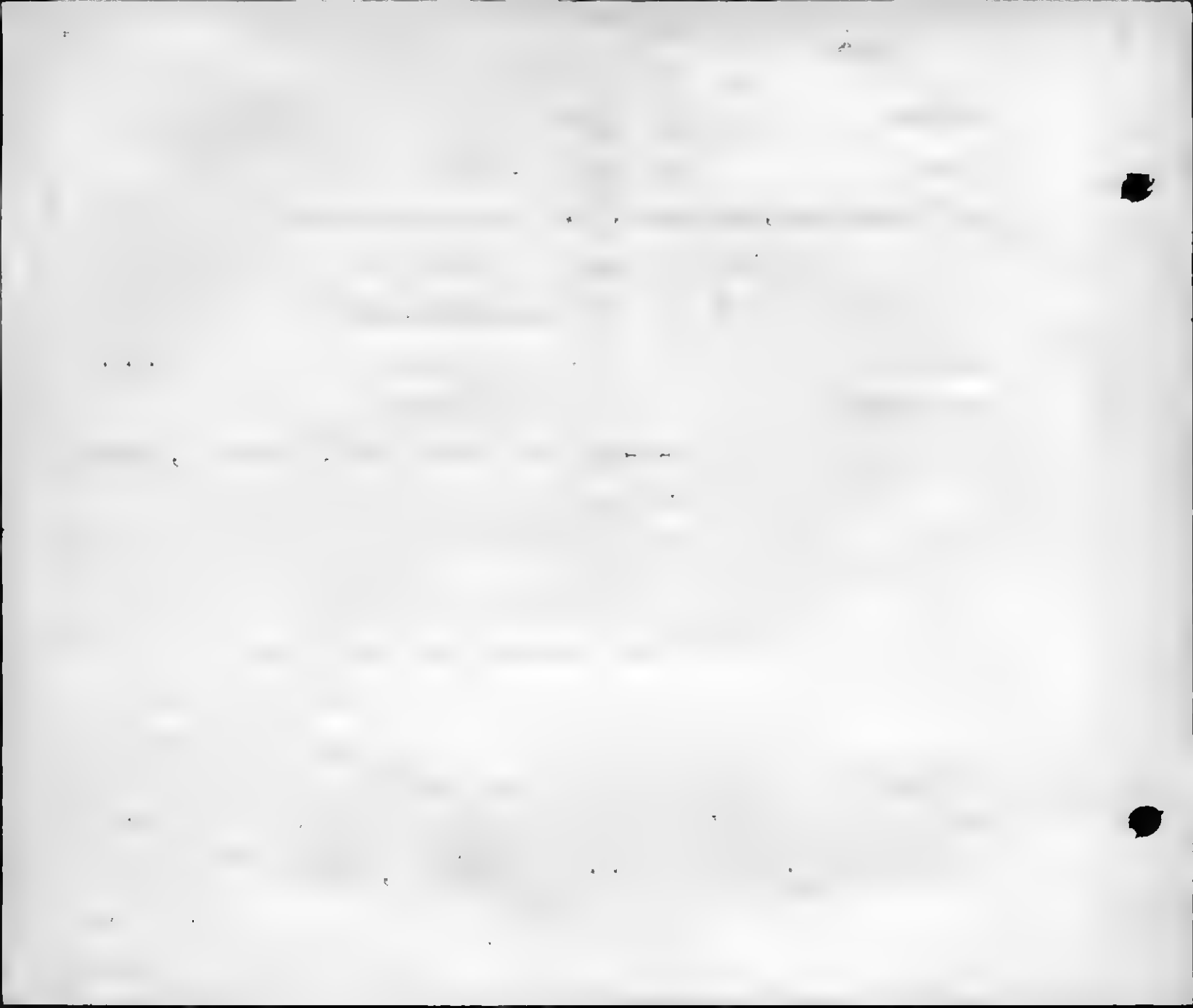
## CERTIFICATE OF DEATH

Reg. Dist. No.

09206

1. PLACE OF DEATH -- a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>142 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>6720 North 25th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martin Luther Copley</b>		4. DATE OF DEATH Month Day Year <b>August 12 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1905</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Moses Copley</b>		14. MOTHER'S MAIDEN NAME <b>Emma Lambert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-05-6953</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Granulocytic Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Tuberculosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1959</b> , to <b>August 12, 1959</b> , that I last saw the deceased alive on <b>August 12, 1959</b> , and that death occurred at <b>12:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/12/59</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 1959</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Wash. National</b>		22d. LOCATION (City, town, or county) (State) <b>Pt. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		24a. REC'D BY REGISTRAR <b>1400 Chapin St. N.W.</b> <b>Wash. D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Hanks</b>		24c. DATE <b>AUG 14 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

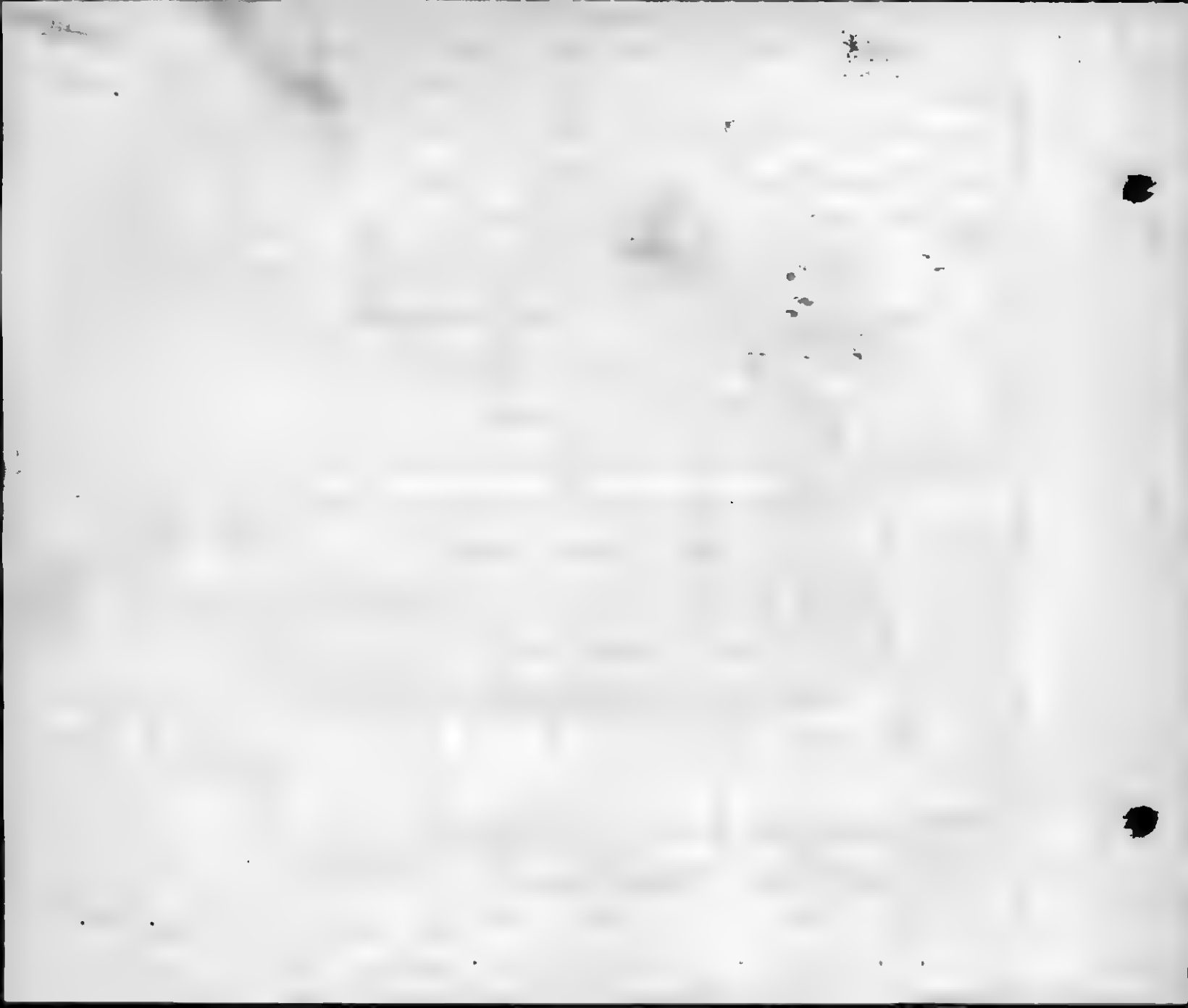
09207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Wesssex Rd</u>				d. STREET ADDRESS <u>14 Wesssex Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leslie</u> Last <u>Cranford</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-7-1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Supply Co</u>		11. BIRTHPLACE (State or foreign country) <u>S. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Cranford</u>				14. MOTHER'S MAIDEN NAME <u>Ann Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #2</u>		17. INFORMANT <u>Mary Cranford</u>		Address <u>Illin 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage + laceration</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate (b) _____ (a), stating the underlying DUE TO cause last. (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in skull</u>					
20c. TIME OF INJURY Month, Day, Year <u>16:20 p.m. 8-27 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-27-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

9265

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

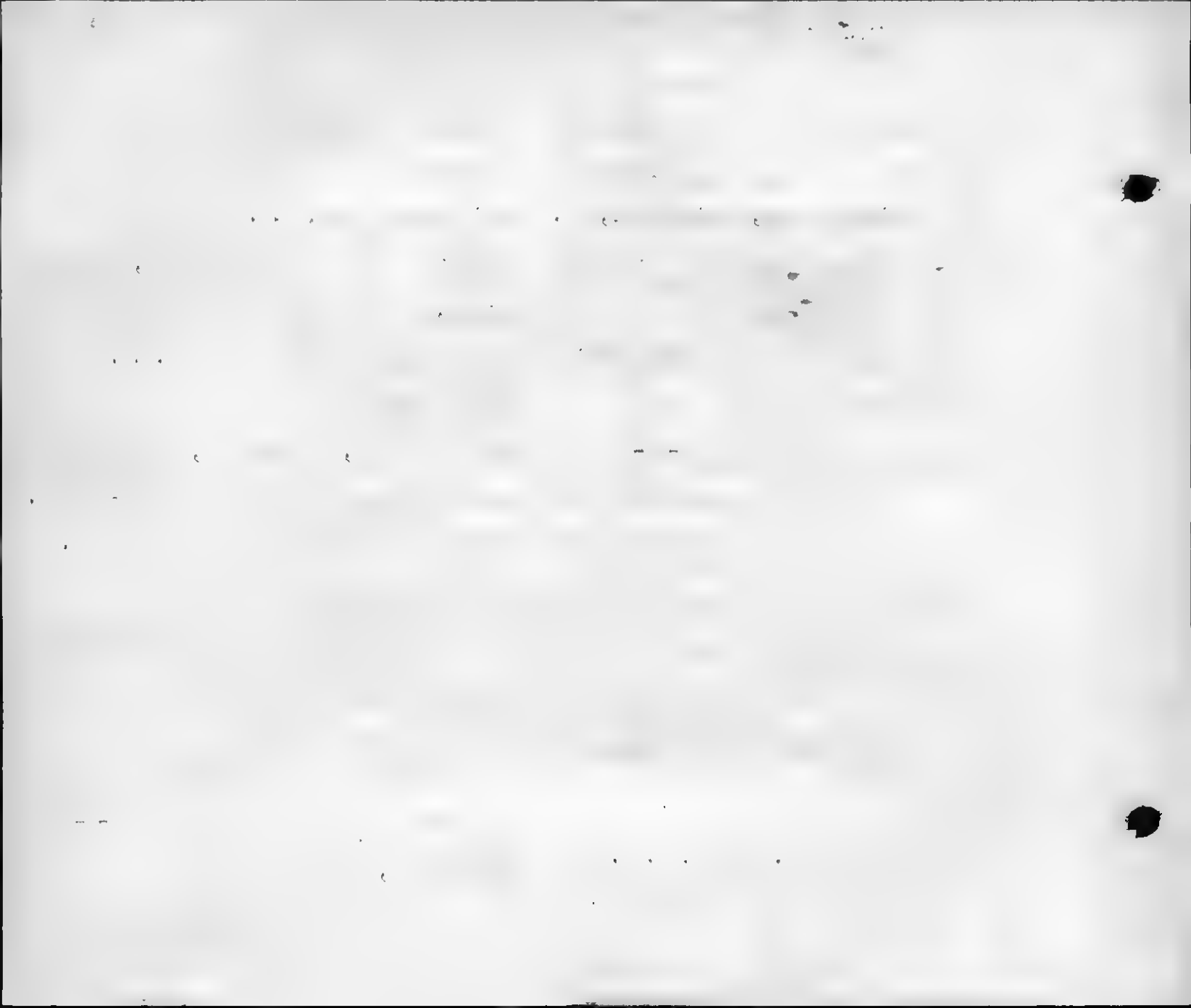
CERTIFICATE OF DEATH

09208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>75 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				d. STREET ADDRESS <b>2523 Palmer Place, S.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Courtney</b> Last <b>Custer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1921</b>	
9. AGE (In years last birthday) <b>38</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photo Engraver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Business Machines</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Custer</b>				14. MOTHER'S MAIDEN NAME <b>ELSIE Jessie Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>577-28-8070</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from lung into trachea &amp; bronchi</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Teratocarcinoma of testes with metastasis to lungs</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5-10 min.</b> <b>4 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 19 1959</b> to <b>August 2 1959</b> , that I last saw the deceased alive on <b>August 2 1959</b> , and that death occurred at <b>6:40 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-2-59</b> ACTUAL SIGNATURE <b>L. A. Gaydos</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Blacksburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Washington, D. C.</b>				24. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION





9230

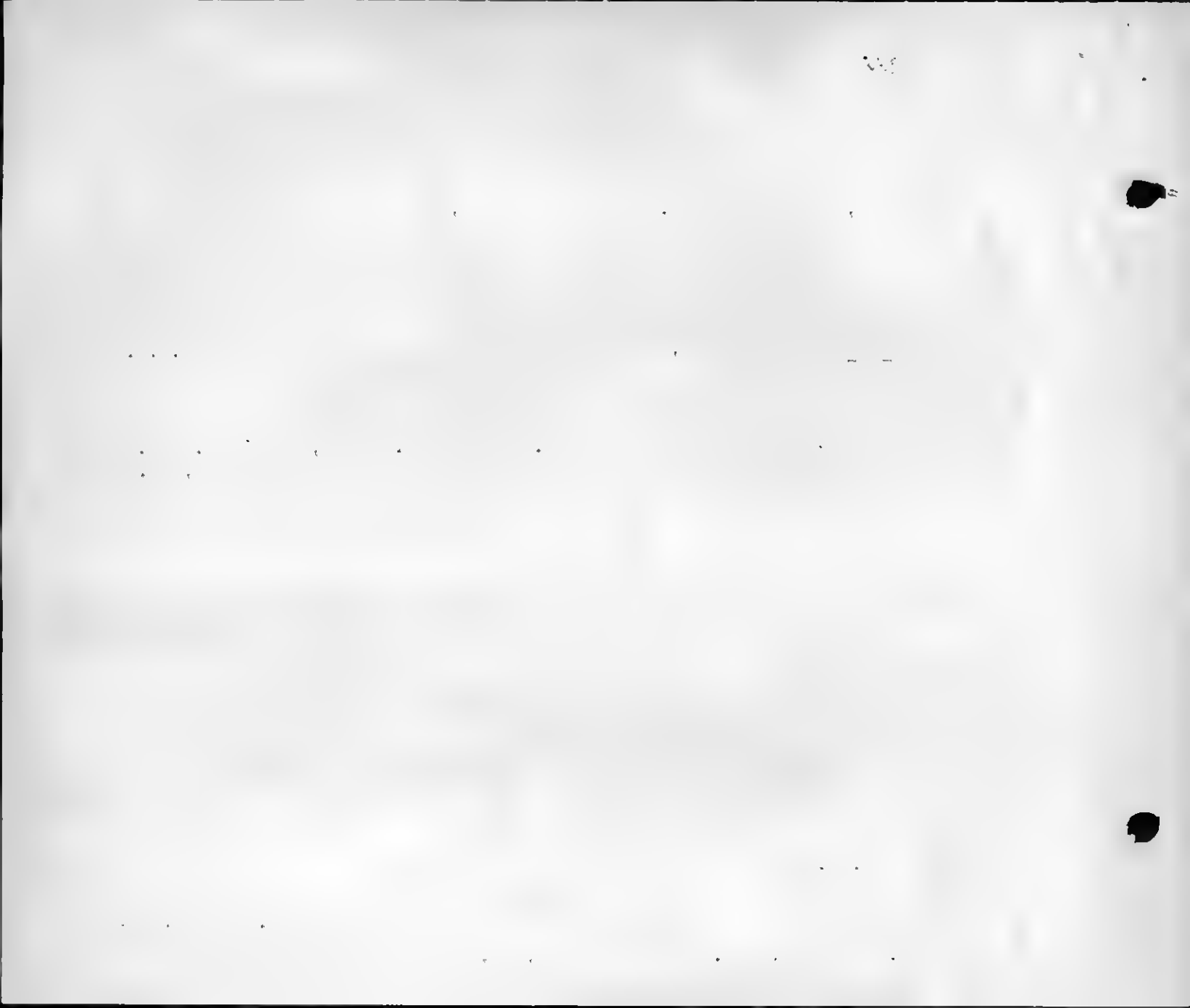
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>	
c. LENGTH OF STAY IN 1b <b>27 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14,712 GEORGIA AVE.</b>		d. STREET ADDRESS <b>14,712 GEORGIA AVENUE</b>	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>RYAN</b> Last <b>DAILY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/97</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY-AT-LAW</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WELSH, DAILY &amp; WELSH ILLINOIS</b>	
11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN RYAN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET DAILY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Mrs. Florence T. Daily, 14712 Ga. Ave.</b>		Address <b>Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of stomach</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mths</b> <b>18 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1/58</b> to <b>8/1/59</b> , 1958 to 1959, that I last saw the deceased alive on <b>8/9/59</b> , 1959, and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. BIRD</b>		ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. W. BIRD</b>		DATE SIGNED <b>8/11/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond H. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. E. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9266

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

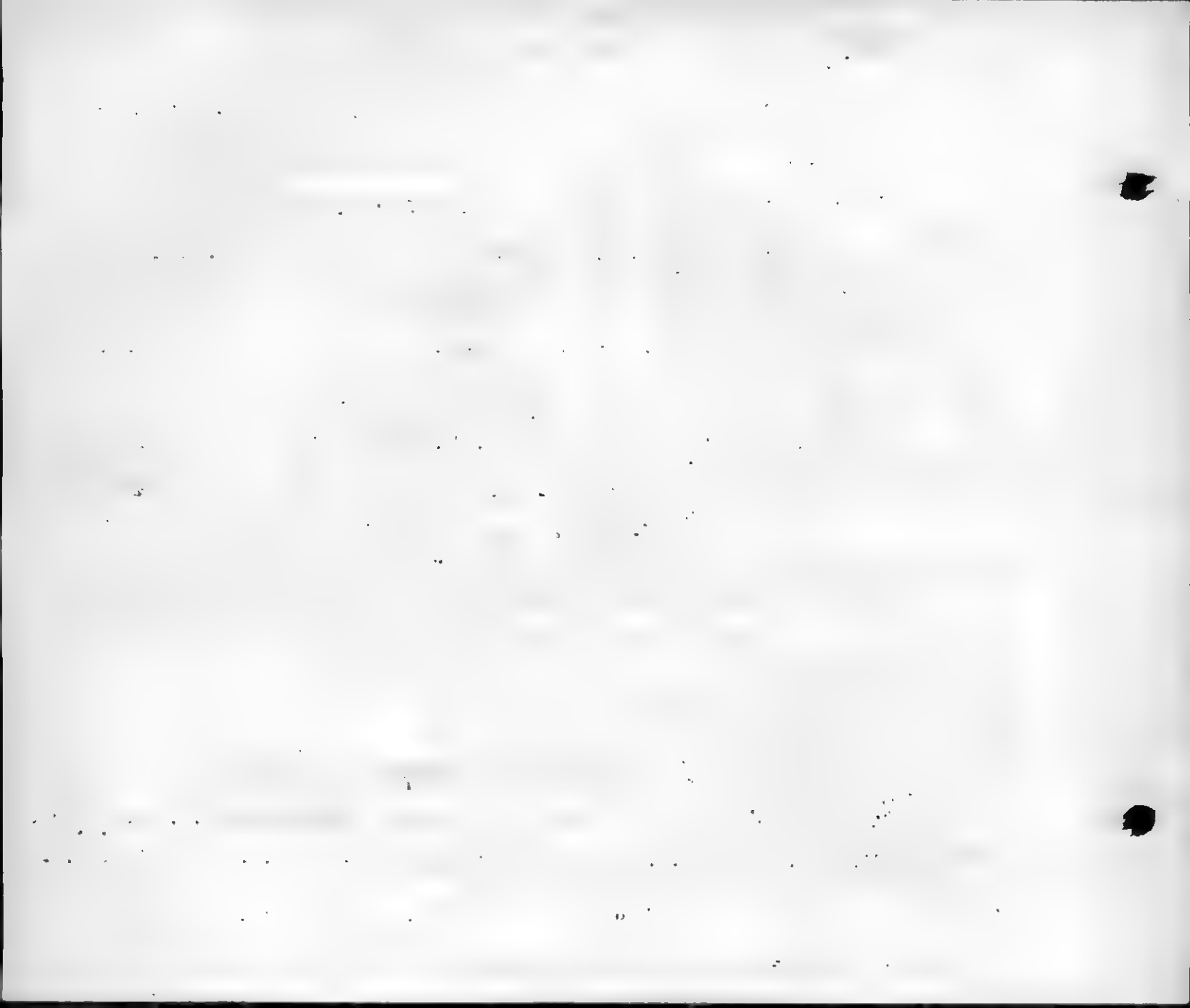
Reg. Dist. No.

09210

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5318 Bangor Drive</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>	
f. STREET ADDRESS <b>5318 Bangor Drive</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>FRANCIS</b> Last <b>DANEHY</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>13,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1909</b>
9. AGE (In years last birthday) <b>50 yrs</b>		10. IF UNDER 1 YEAR <b>0</b> Months <b>14</b> Days <b>0</b> Hours <b>0</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John G. Danehy</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Flynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mary S. Danehy - Wife - Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>154X</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Carcinoma of rectum</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 Aug. 19 59</b> to <b>13 Aug 19 59</b> , that I last saw the deceased alive on <b>12 Aug. 19 59</b> , and that death occurred at <b>2:30</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>D.C.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Vincent M. Iovine</b> M.D.		1150 Connecticut Avenue, N.W. Washington, D.C.	
PHYSICIAN'S NAME (Type) <b>VINCENT M. IOVINE, M.D.</b>		1150 Connecticut Avenue, N.W. Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.



9267

CERTIFICATE OF DEATH

09211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 Deer Park Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WILLIAM</b> Last <b>DARNELL</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harvey Darnell</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Cox</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Alice Suddueth-123 Deer Park Dr.-Gaithersburg-Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PERIODIC CEREBRAL HYPERTENSION</b> DUE TO (c) <b>ARTERIOSCLECTIC HEART DISEASE</b> - CYANOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b> <b>15 YEARS</b> <b>- CYANOSIS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>August 1954</b> , to <b>August 1959</b> , that I last saw the deceased alive on <b>August 1959</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.		ADDRESS (Street, city or town, state) <b>26 N. Summit Ave</b> DATE SIGNED <b>20 Aug 1959</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>8/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9268

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

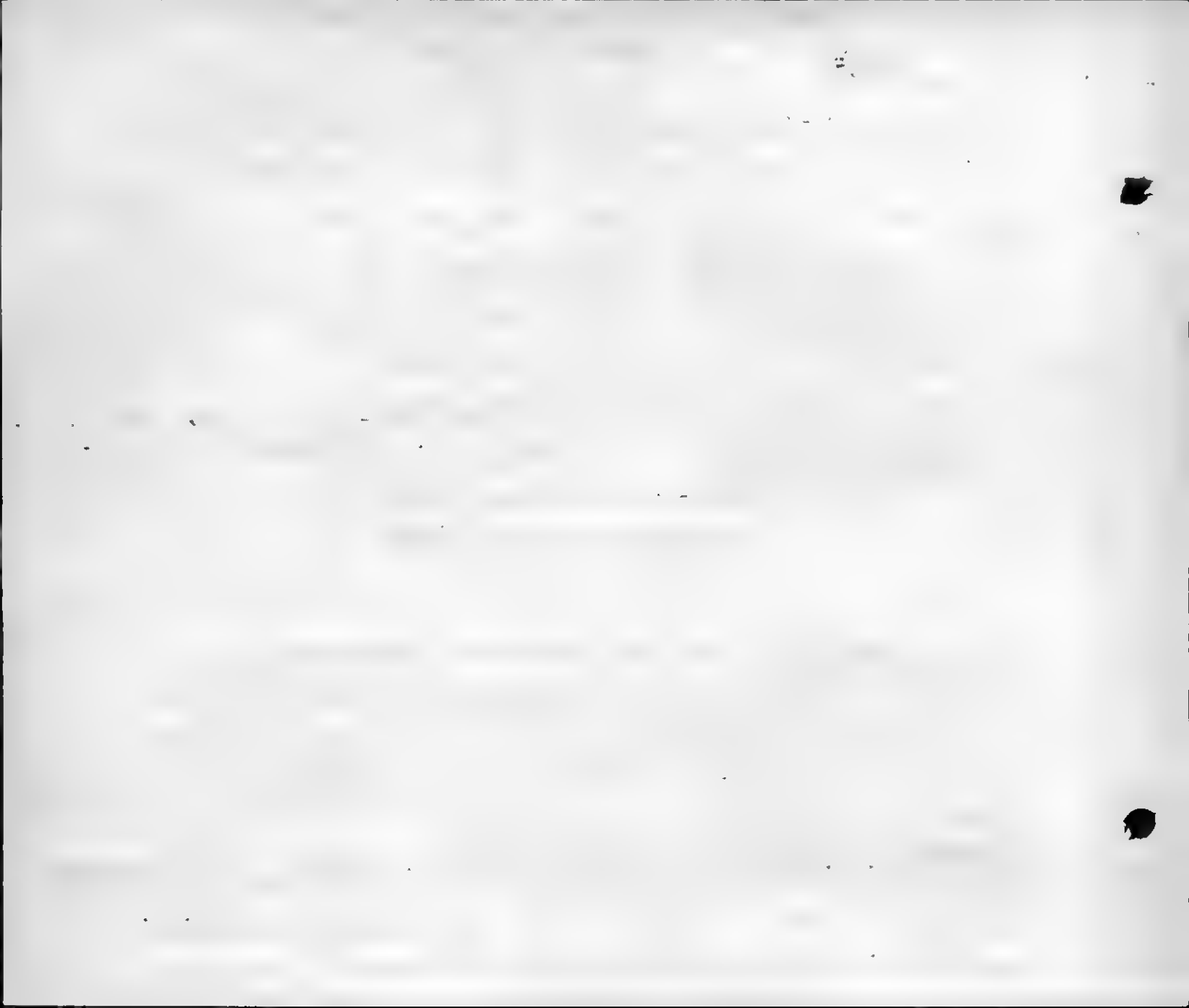
Items 13, 14 File 3247 8-27-59 et

CERTIFICATE OF DEATH

09212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> County <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 mos. 2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San</u>				e. STREET ADDRESS <u>Silver Spring</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>B</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1939</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1878</u>	9. AGE (In years last birthday) <u>80</u> yrs	10. IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Allison</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Self</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>daughter-Charlotte D. Hiser-8026 Glendale Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Chronic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> (c) <u>Chronic vascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug 8, 1959</u> , to <u>Aug 20, 1959</u> , that I last saw the deceased alive on <u>Aug 19, 1959</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. T. Joyce</u>				DATE SIGNED <u>Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>W. T. Joyce</u>				<u>Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kunkel</u>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

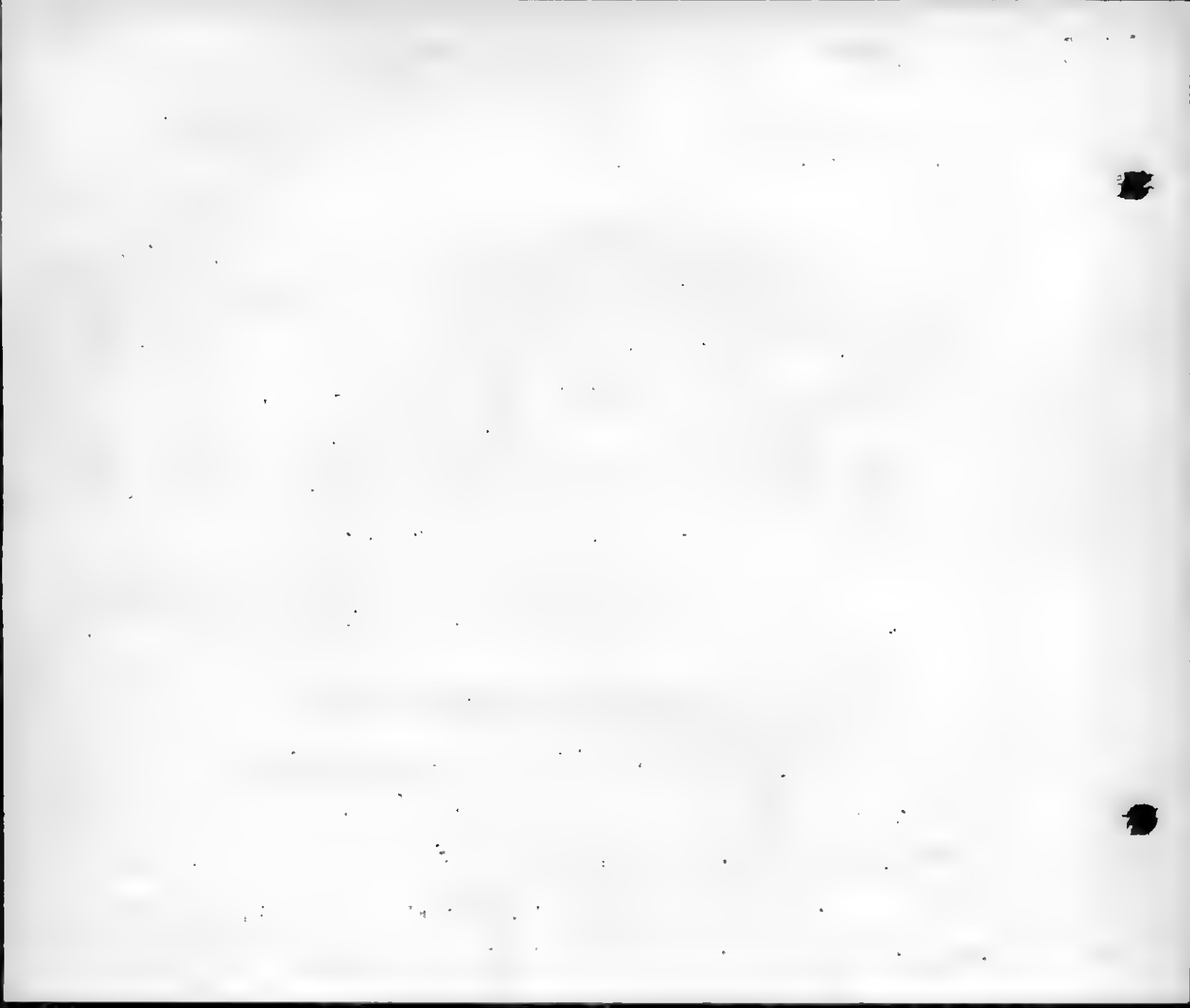
09213

9269

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 MIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. STREET ADDRESS <u>103 E INDIAN SP DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>LYNN</u> Last <u>DeMott</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 25 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Att.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ken Motors</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES DeMott</u>		14. MOTHER'S MAIDEN NAME <u>FLORA AVERY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>ARMY</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
INFORMANT <u>Wife</u> Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>42.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Initial Valvulitis of Endocarditis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>Aug 26, 1959</u> that I last saw the deceased alive on <u>Aug 26, 1959</u> , and that death occurred at <u>9:13 M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> DATE SIGNED <u>8/26/59</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>

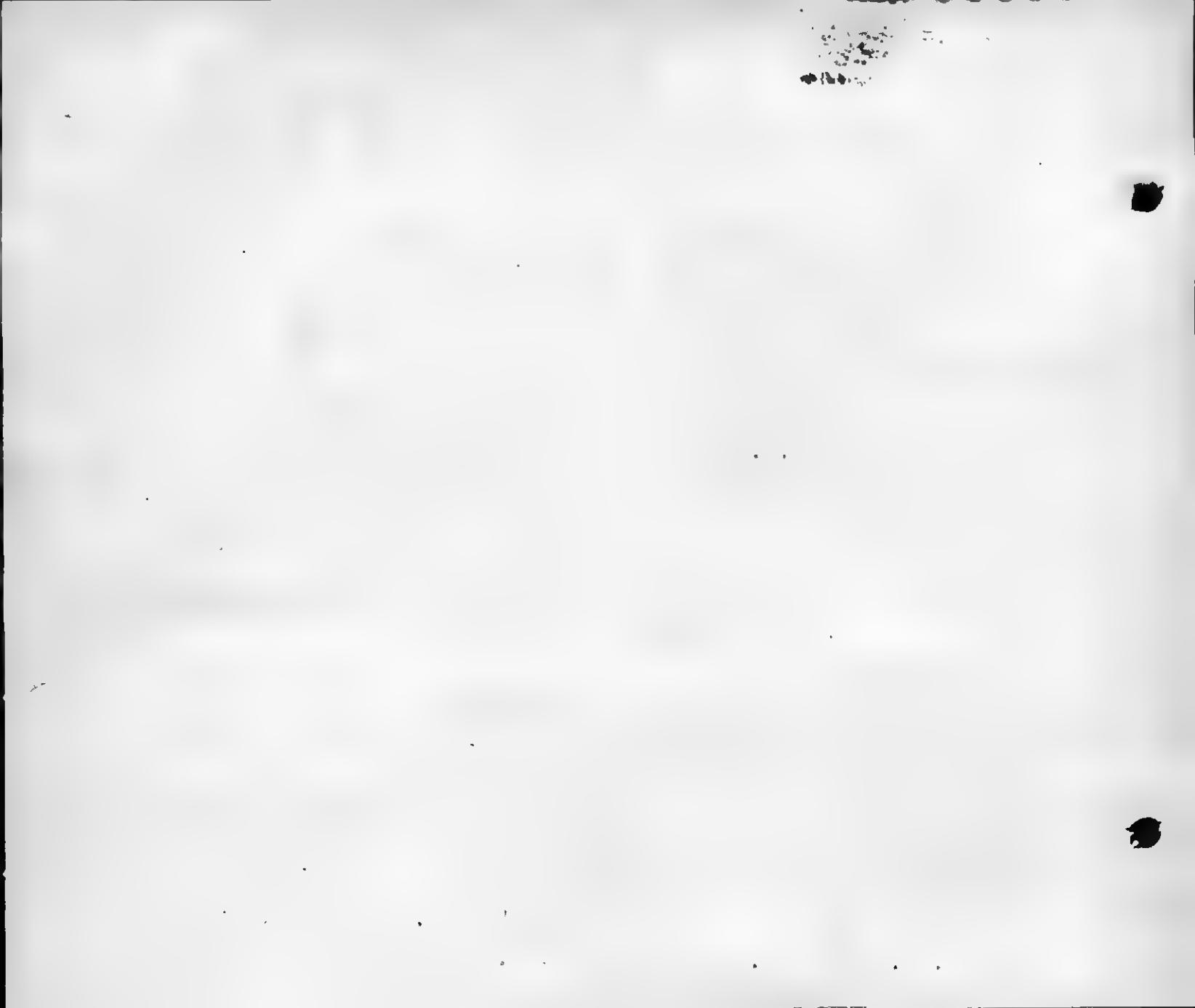


## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>5437 Conn. Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Arthur Desmarais</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-99</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sg. Police - Dept of State</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Desmarais</u>		14. MOTHER'S MAIDEN NAME <u>Adele Ganeau</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army W.W. #1 none</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 HOURS</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>AUG. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG. 3</u> , 19 <u>59</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>		ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE N.W.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		DATE SIGNED <u>AUG 4 1959</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9270

## CERTIFICATE OF DEATH

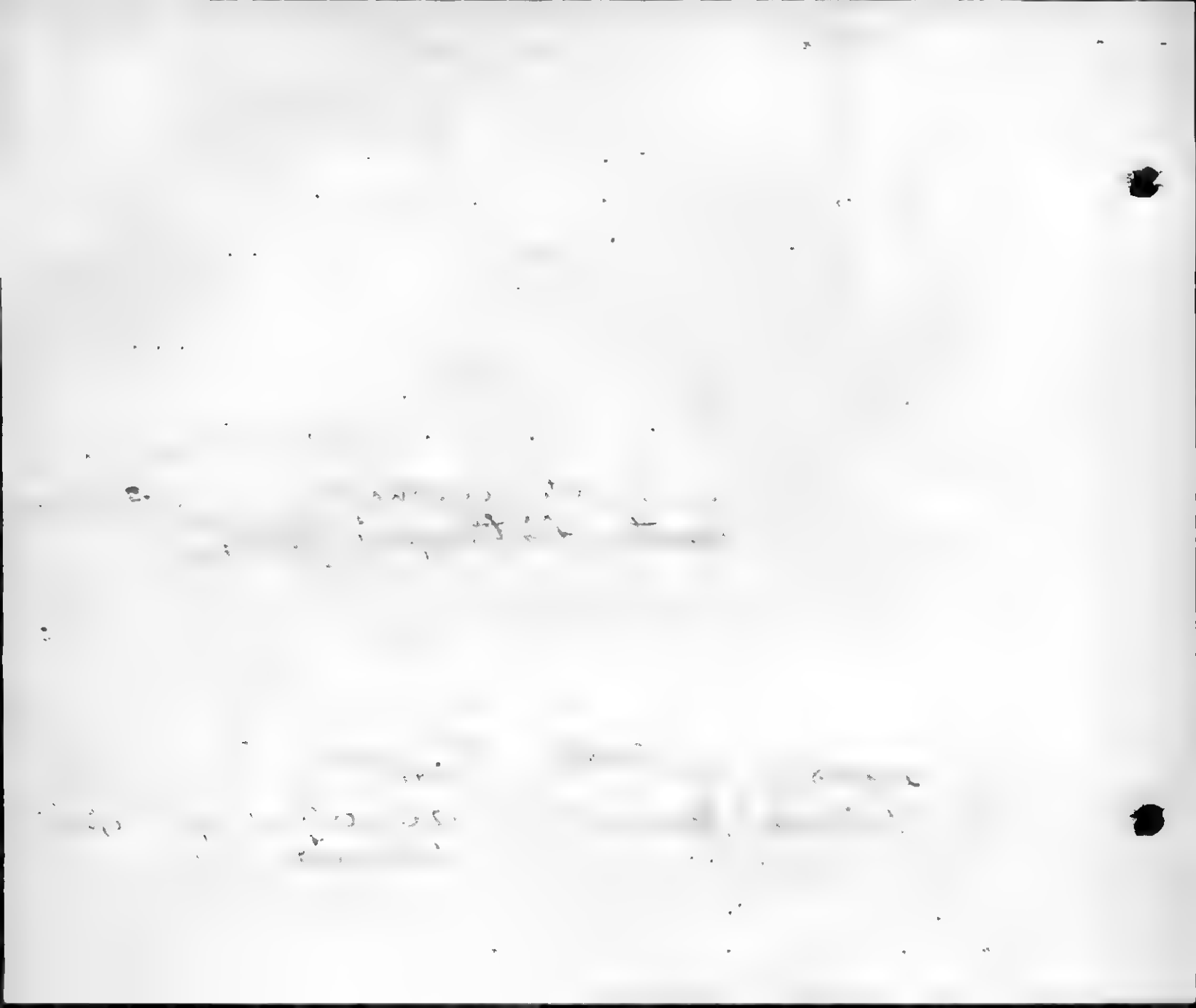
09215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13,200 Lutes Lane</b>		d. STREET ADDRESS <b>13,200 Lutes Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>SHIRLEY</b> Middle <b>ANN</b> Last <b>DRAUGHAN</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/27/41</b>
9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALVAH L. DRAUGHAN</b>	
14. MOTHER'S MAIDEN NAME <b>LULA F. COX</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO <b>NONE</b>		INFORMANT <b>Mr. Alvah L. Draughan, 13,200 Lutes Lane Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>351X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Spastic birth injury (cerebral palsy)</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 27</b> , 19 <b>59</b> , to <b>Aug 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 28</b> , 19 <b>59</b> , and that death occurred at <b>11:45</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Patrick C. Jameson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>12020 Georgia Wheaton, Tex 8/30/59</b>	
PHYSICIAN'S NAME (Type) <b>PATRICK C. JAMESON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>	22b. DATE THEREOF <b>8/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FRIES CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>FRIES, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

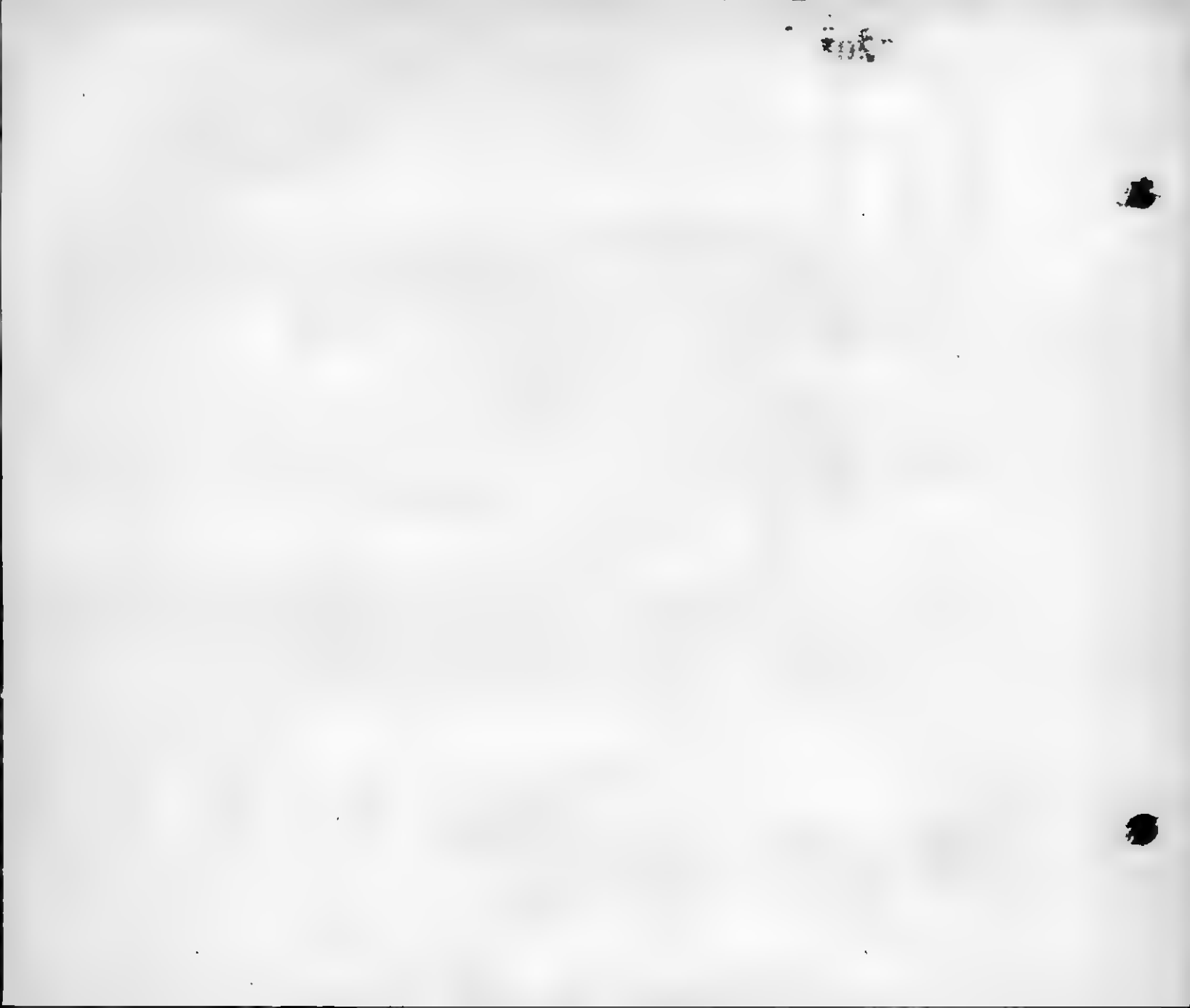
9207

## CERTIFICATE OF DEATH

09216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester, Maryland Box 47</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Thomas Shellcross Dreer</u>		4. DATE OF DEATH <u>August 4 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 29, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>59</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Nicholas D. Dreer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S. Vausant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Washington San &amp; Hosp Records</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Neurofibromatosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1959</u> , to <u>Aug. 4, 1959</u> , that I last saw the deceased alive on <u>Aug. 4, 1959</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D. <u>7600 Carroll Ave., Takoma Park 8-4-59</u>		DATE SIGNED <u>md.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Lane</u> ADDRESS <u>Chapel Hill Md.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	





9271

## CERTIFICATE OF DEATH

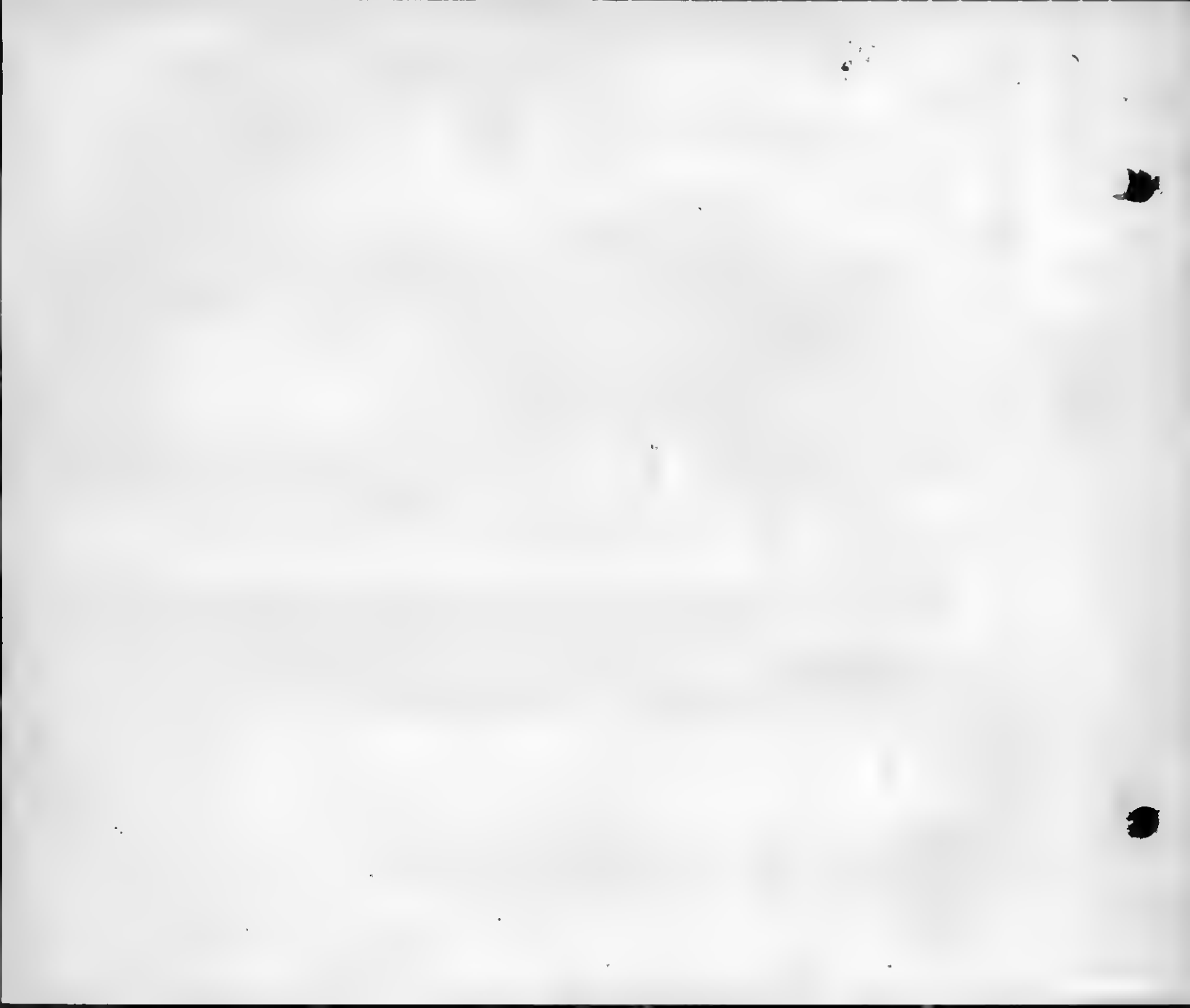
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>10 mo</u>		d. STREET ADDRESS <u>6504 Stoneham Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>August Wilhelm Dyker</u>		4. DATE OF DEATH <u>Aug. 19- 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 6-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jan Augustin Dyker</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Driesen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>345-04-5553</u>	
17. INFORMANT <u>Hospital Records &amp; Son</u>		Address <u>6504 Stoneham Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>General arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>undetermined</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-2-</u> , 19 <u>59</u> , to <u>8-19-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-10-</u> , 19 <u>59</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>8-19-59</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>		<u>Riverdale, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>AUG 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kras</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9272

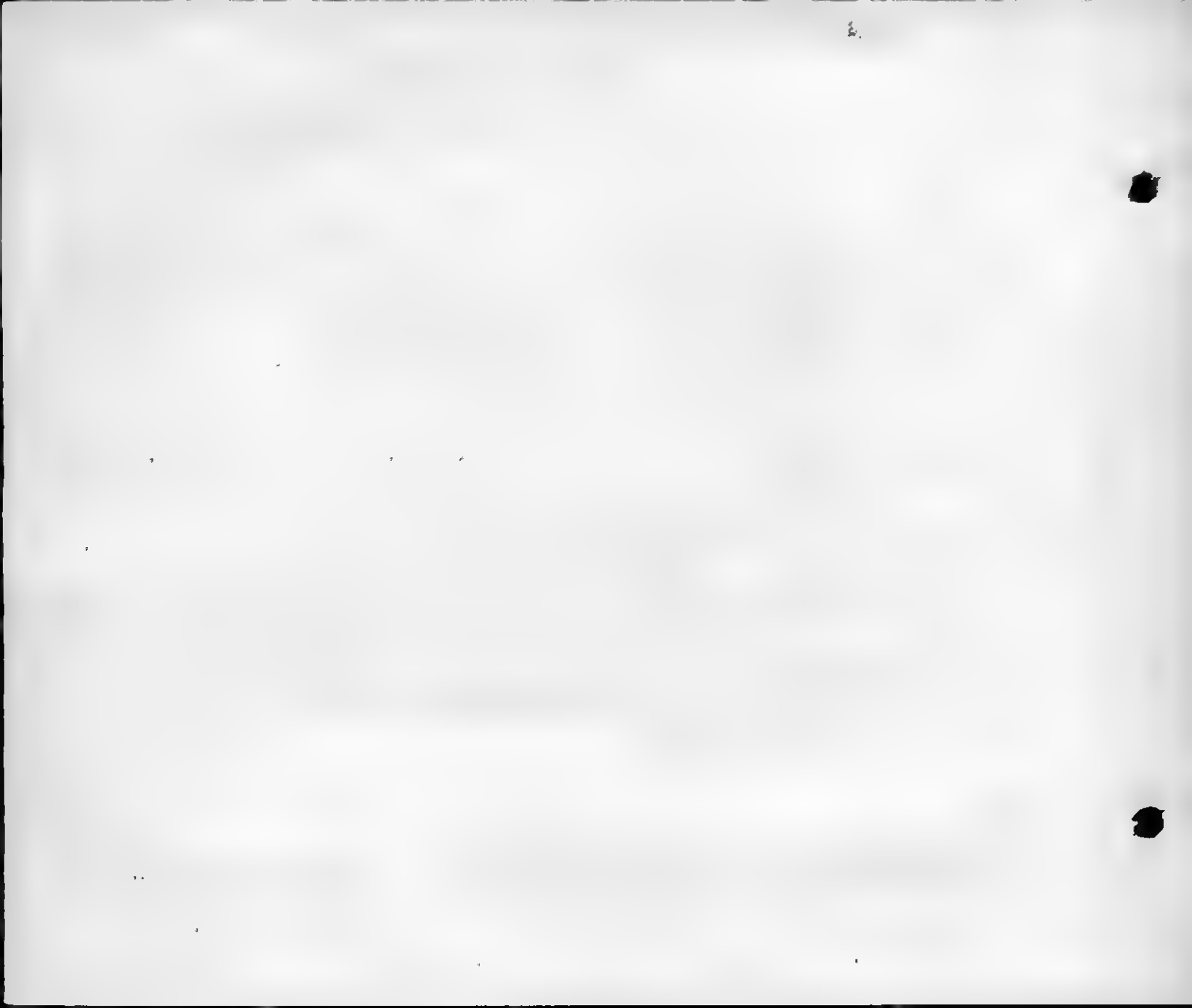
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Monte</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Monte</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>76 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Essie</u> Middle <u>M</u> Last <u>Lly</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>26</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>!!!</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles W. Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Cornell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John B. Lly. Gaithersburg, Md.</u>		Address <u>3-Russel Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic cardio-renal disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>8/22/</u> 1959, that I last saw the deceased alive on <u>8/20/</u> 1959, and that death occurred at <u>2</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/22/59</u>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		PHYSICIAN'S NAME (Type) <u>Frank J. Broschart</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Gaithersburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09219

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1620 "V" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERITANO</b>			4. DATE OF DEATH Month Day Year <b>August 1 1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-31-59</b>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>26</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Peter J. ERITANO</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>(Father) Peter J. ERITANO</b>			Address <b>Same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurely</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>31 July 1959</b> to <b>1 August 1959</b> , that I last saw the deceased alive on <b>1 August 1959</b> , and that death occurred at <b>3:22 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>8-3-59</b>							
ACTUAL SIGNATURE <i>D. Harris</i>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>D. HARRIS, LT, MC, USN</b>		<b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest P. Roberts</i> <b>Ernest P. Roberts</b> <b>1748 Wisconsin Ave. N.W. Washington, D.C.</b>			24a. REC'D BY REGISTRAR DATE <b>AUG 6 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Charles S. House</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

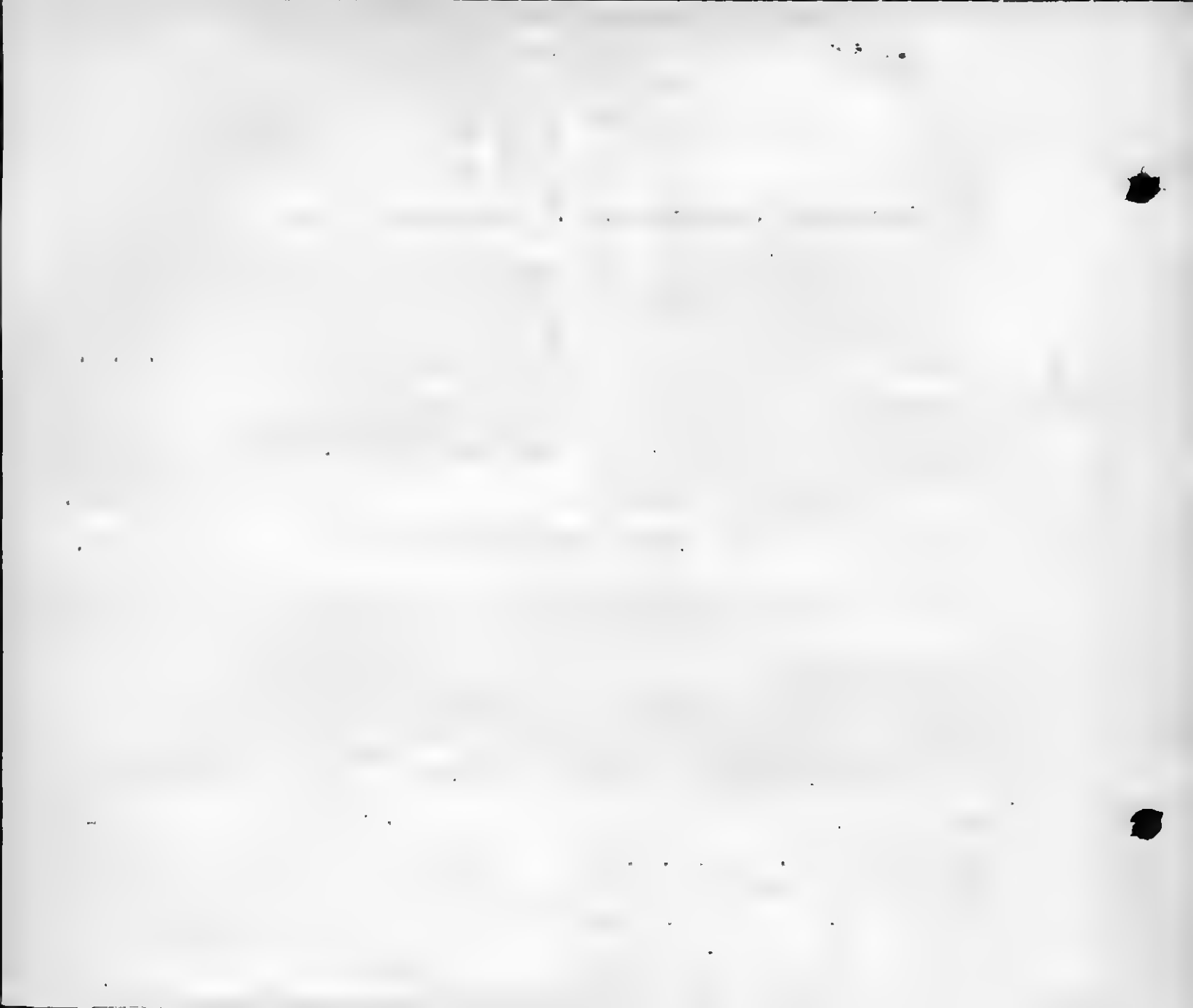
09220

9274

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>64 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>905 Kenbrook Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Riva</b>		First <b>Riva</b> Middle <b>(none)</b> Last <b>Essrick</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1921</b>		9. AGE (In years last birthday) yrs <b>38</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hyman Krakuzin</b>				14. MOTHER'S MAIDEN NAME <b>Rose Sokol</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b> 705.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Systemic Lupus Erythematosus</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 mons.</b> <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>7:50 P</b> .M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-5-59</b> ACTUAL SIGNATURE <b>George T. Bryan</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>George T. Bryan, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons - 3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





9275

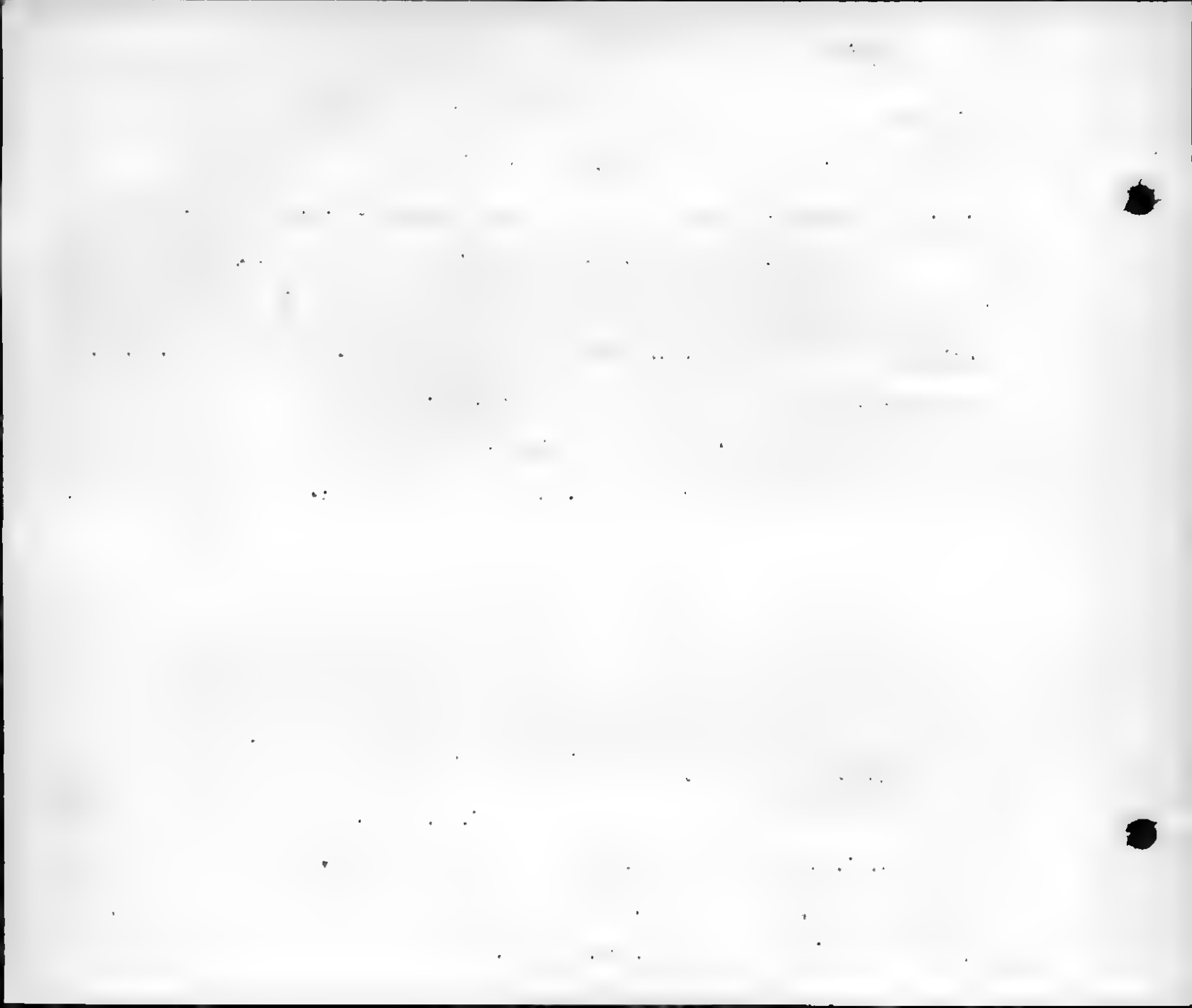
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>181 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4000 Cathedral Ave., NW - Apt. 221E</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First <b>Edward</b>		Middle <b>Coyle</b>		Last <b>EWEN</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>13</b>		Year <b>19 59</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-97</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b>		IF UNDER 24 HRS Days <b>62</b>		Hours <b>62</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>				11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>George S. EWEN</b>								14. MOTHER'S MAIDEN NAME <b>Jessica COOTS</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>								16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WWI, WWII, Korea Unknown</b>								17. ADDRESS <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, rectum, with metastases</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that I attended the deceased from <b>February 13, 19 59</b> , to <b>August 13, 19 59</b> , that I last saw the deceased alive on <b>August 13, 19 59</b> , and that death occurred at <b>3:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>8-13-59</b>																			
ACTUAL SIGNATURE <b>G. I. Walker</b> M.D. <b>U. S. Naval Hospital</b>																			
PHYSICIAN'S NAME (Type) <b>G. I. WALKER, CAPT, MC, USN</b>								Bethesda, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				22b. DATE THEREOF <b>8-14-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills Crematory</b>				22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler's &amp; Sons, 1756 Penn. Ave. NW, Wash. DC</b>								24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

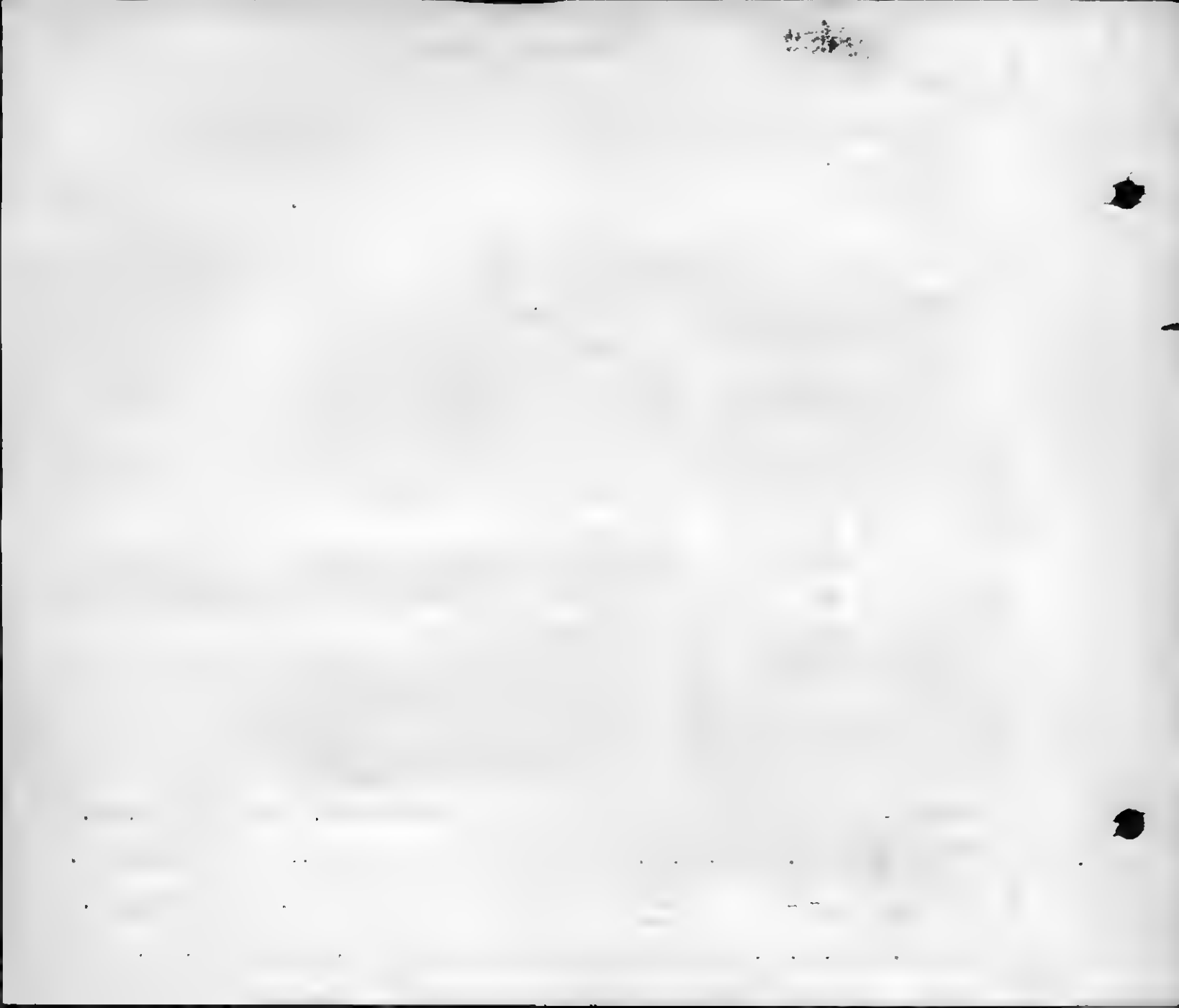
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>11711 Berwick Rd.,</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Fairfax</b>				4. DATE OF DEATH Month Day Year <b>August 1, 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1959</b>		9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Carl Spogard Fairfax</b>				14. MOTHER'S MAIDEN NAME <b>Tvonne Dorothy Goodeve</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>father</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) <b>Premature Separation Placenta</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/1, 1959</b> to <b>8/1, 1959</b> that I last saw the deceased alive on <b>8/1, 1959</b> , and that death occurred at <b>8:55 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>925 Pershing Dr., Silver Spring, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Raymond F. Chinn</b>				M.D. <b>925 Pershing Dr., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Raymond F. Chinn, M. D.</b>				<b>925 Pershing Dr., Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>8-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>				ADDRESS <b>Washington Sanitarium and Hospital, Takoma Park, 12, Maryland</b>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15M 9/55

2075211X52

AUG 5 '59

Arthur S. Fraws



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

09223

9276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs</u>				d. STREET ADDRESS <u>7706 Meadow Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7706 Meadow Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alma Lawrence Felker</u> First Middle Last				4. DATE OF DEATH <u>Aug 30 1959</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-1895</u> yrs.	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mo</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert W. Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lee Withel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Edward P. Felker - Son</u> Address <u>Stem 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>hypertension</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>8/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Wash D</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
24c. ADDRESS <u>5105 St. ...</u>				24d. DATE <u>SEP 2 '59</u>		24e. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9209

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09224

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyatt, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. and Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLAVEN, MR. JOHN PATRICK</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-10</u>
9. AGE (In years lost birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMERSON RESEARCH LAB</u>	
11. BIRTHPLACE (State or foreign country) <u>Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN FLAVEN</u>		14. MOTHER'S MAIDEN NAME <u>Catherine McCarthy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> If yes, give war or date of service <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>262 12 7897</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> 113X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epidermoid carcinoma, undifferentiated, lung</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/23</u> , 19 <u>59</u> , to <u>8/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>1035 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin L. Kolkin</u> M.D.		ADDRESS (Street, city or town, state) <u>8485 Fenton Street, S.S., Md.</u> DATE SIGNED <u>8/28/59</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN L. KOLKIN</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <u>SEPT. 1, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Harris</u> ADDRESS <u>254 CARROLL ST. N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christina L. Harris</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9277

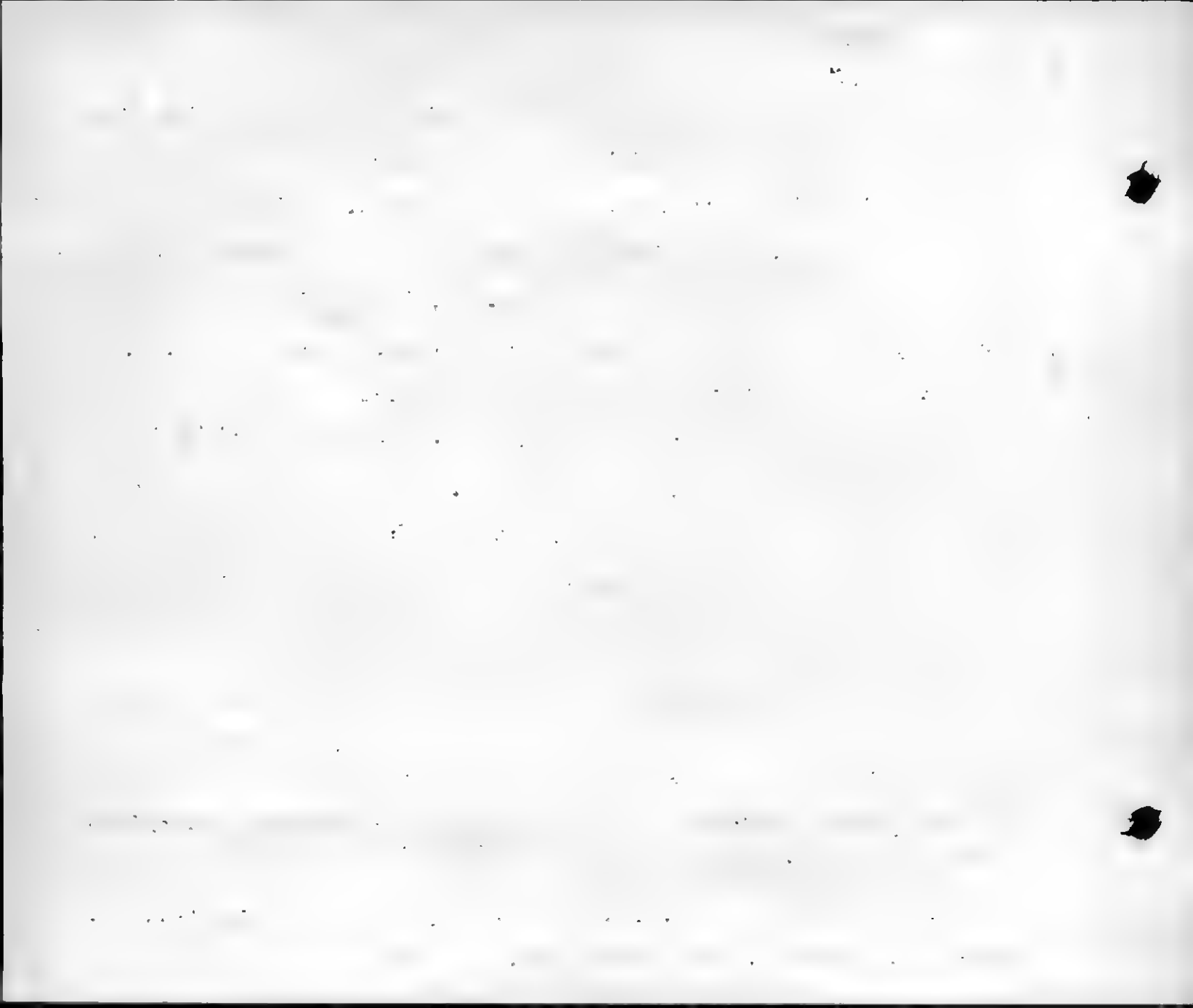
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8201 Kentbury Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NANCY JOHNSON FLEMING</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 6, 19 59</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 25, 1901</b>
9 AGE (In years last birthday) <b>57</b> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>11</b> Days <b>11</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Anders Johnson</b>		14 MOTHER'S MAIDEN NAME <b>Nancy Larson</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>None</b>	
INFORMANT <b>Husband</b> Address <b>Same as Item #2</b>		Chapman C. Fleming	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Ca. of Lung, Liver, Spleen, Spleen &amp; Skull</b> DUE TO (c) <b>Carcinoma of Left Breast - Removed Aug. 1956</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b> <b>12 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1958</b> , to <b>6 Aug 1959</b> that I last saw the deceased alive on <b>3 Aug 1959</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Old Georgetown Rd. Bethesda 14, Maryland</b> DATE SIGNED <b>8/6/59</b>			
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D. <b>7936 Old Georgetown Rd. Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



9278

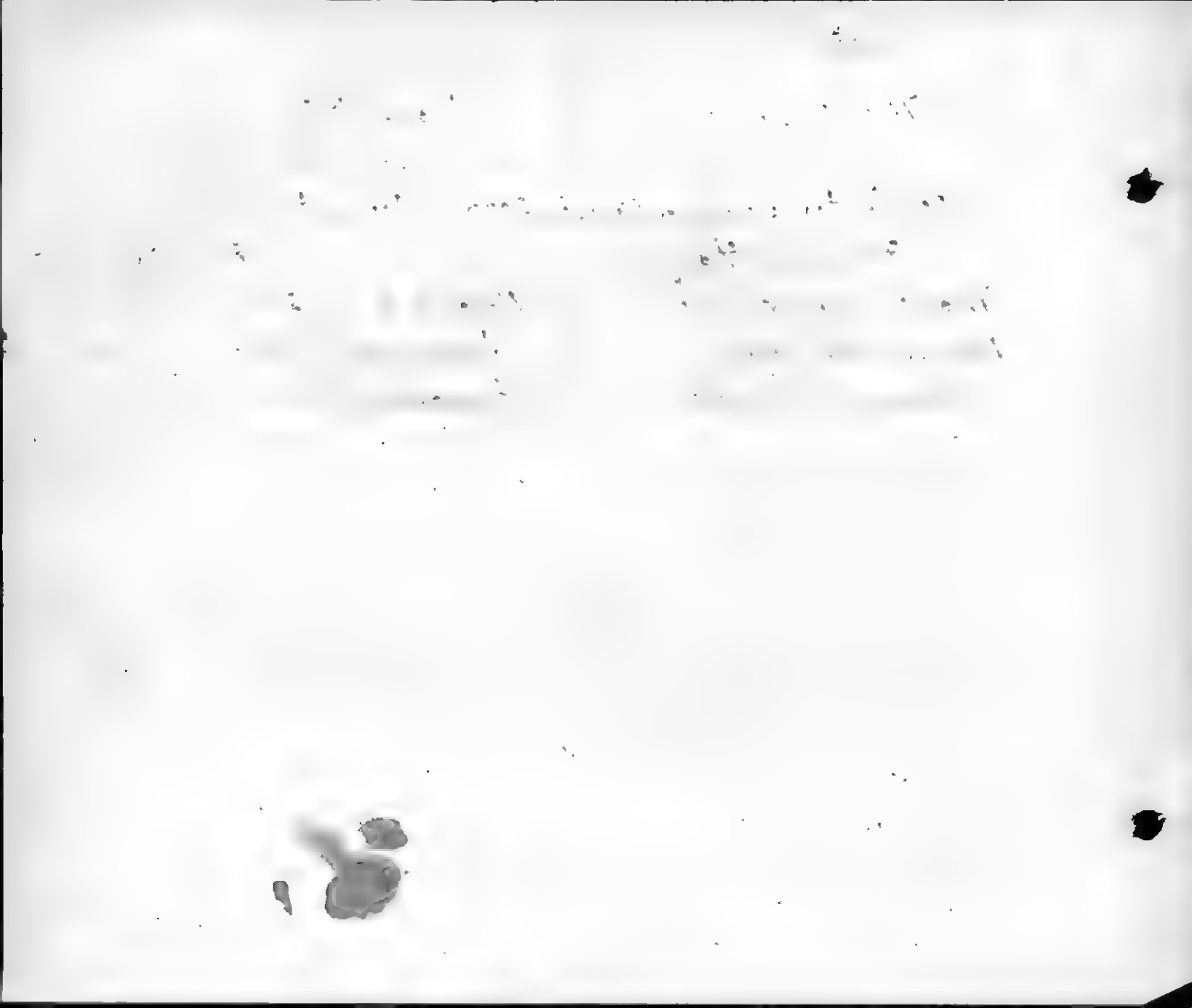
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>		d. STREET ADDRESS <u>215 EMERSON NW</u> 3000 McComas Ave.	
3. NAME OF DECEASED (Type or print) <u>LAST First Middle</u> <u>Flicker, Harry</u>		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-69</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>26</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov. Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cincinnati Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Flicker</u>		14. MOTHER'S MAIDEN NAME <u>wife Emma Louise Flicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Edna Simpson</u>		Address <u>215 EMERSON NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Aug 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>59</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter K. Angermeier</u>		ADDRESS (Street, city or town, state) <u>6350 - 13th St, NW, Wash. D.C.</u> DATE SIGNED <u>8/26/59</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-29-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Lunsford Hane</u> ADDRESS <u>4812 E. Annapolis</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9279

## CERTIFICATE OF DEATH

Reg. Dist. No.

09227

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4611 Hunt Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. STREET ADDRESS <b>4611 Hunt Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA WERNER FONKEN</b>		4. DATE OF DEATH Month Day Year <b>August 2, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1878</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR: Months <b>0</b> Days <b>14</b> IF UNDER 24 HRS: Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sterling, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Werner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pegg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>579-42-6933B</b>	
17. INFORMANT <b>George H. Fonken - Item #2-husband</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Failure</b> DUE TO (c) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>1 hr.</b> <b>2 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 54</b> to <b>8/2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 20, 1959</b> , and that death occurred at <b>7:30 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5707 W. Conner Ave</b> DATE SIGNED <b>8/3/59</b> ACTUAL SIGNATURE <b>Frank Y. Jagers, Jr.</b> M.D. <b>Chevy Chase 15, Md</b> PHYSICIAN'S NAME (Type) <b>Frank Y. Jagers, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans. Bur.</b>	22b. DATE THEREOF <b>8/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Whiteside County, Illinois</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

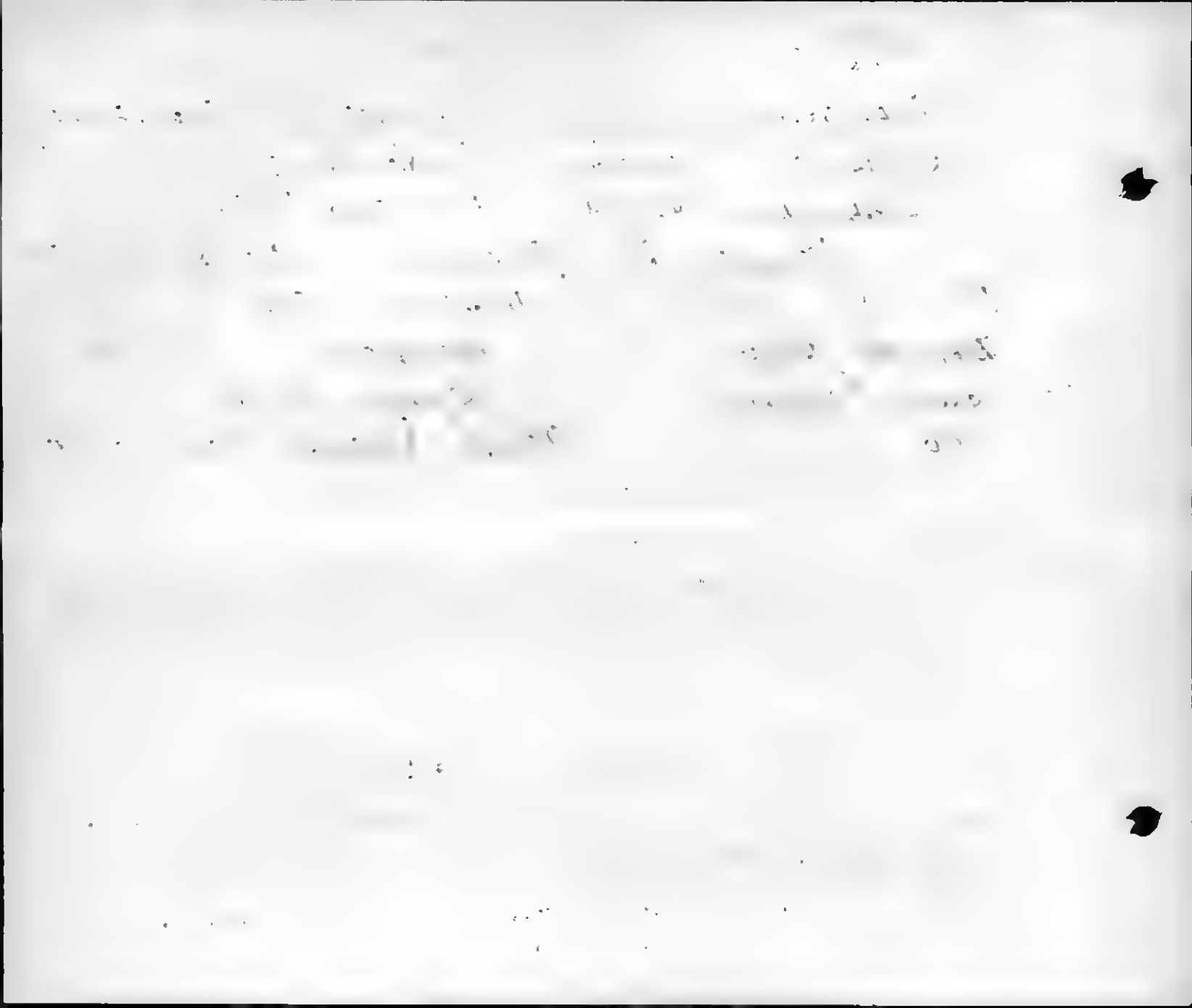


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 9 File G247 8-25-59 et									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09228									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>P.O. Box 283</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie D Frazier</u>					4. DATE OF DEATH Month Day Year <u>August 17 1959</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-21</u>		9. AGE (In years last birthday) <u>38 yr.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Isaac Frazier</u>					14. MOTHER'S MAIDEN NAME <u>Bessie Miles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Mary C. Owens Same - Sister</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>251X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Encephalomalacia</u> DUE TO (c) <u>Tumor, Parietal lobe, left cerebrum</u>									INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status post-operative</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>59</u> , to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>59</u> , and that death occurred at <u>9:20 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 Wisconsin Avenue, Bethesda, Md.</u> DATE SIGNED									
ACTUAL SIGNATURE <u>Robert G. Brewer</u> M.D.									
PHYSICIAN'S NAME (Type) <u>Robert G. Brewer</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.</u>			22d. LOCATION (City, town, or county) (State) <u>Emory Grove, MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u> ADDRESS <u>Rockville, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>		





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

9281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 File 92-1 8-21-59 et

09229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Marland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			c. LENGTH OF STAY IN 1b <b>1 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jerrys Raw Bar</b>				d. STREET ADDRESS <b>110 Ridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Addison</b> Last <b>Frazier</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>21</b> , Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1923</b>		9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lester Frazier</b>				14. MOTHER'S MAIDEN NAME <b>Blanch Pullen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW2</b>		17. INFORMANT <b>Hazel L. Frazier</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> <b>776x</b> DUE TO <b>Bullet wound in rt. skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted bullet wound in rt. skull</b>					
20c. TIME OF INJURY Hour <b>5:00</b> p. m. <b>8/2/59</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>restaurent</b>		20f. (City or town) (County) (State) <b>Gaithersburg Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>8/21/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ParkLawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg. Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION



9282

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 11, 13, 14 File # G248 9-11-59 et

## CERTIFICATE OF DEATH

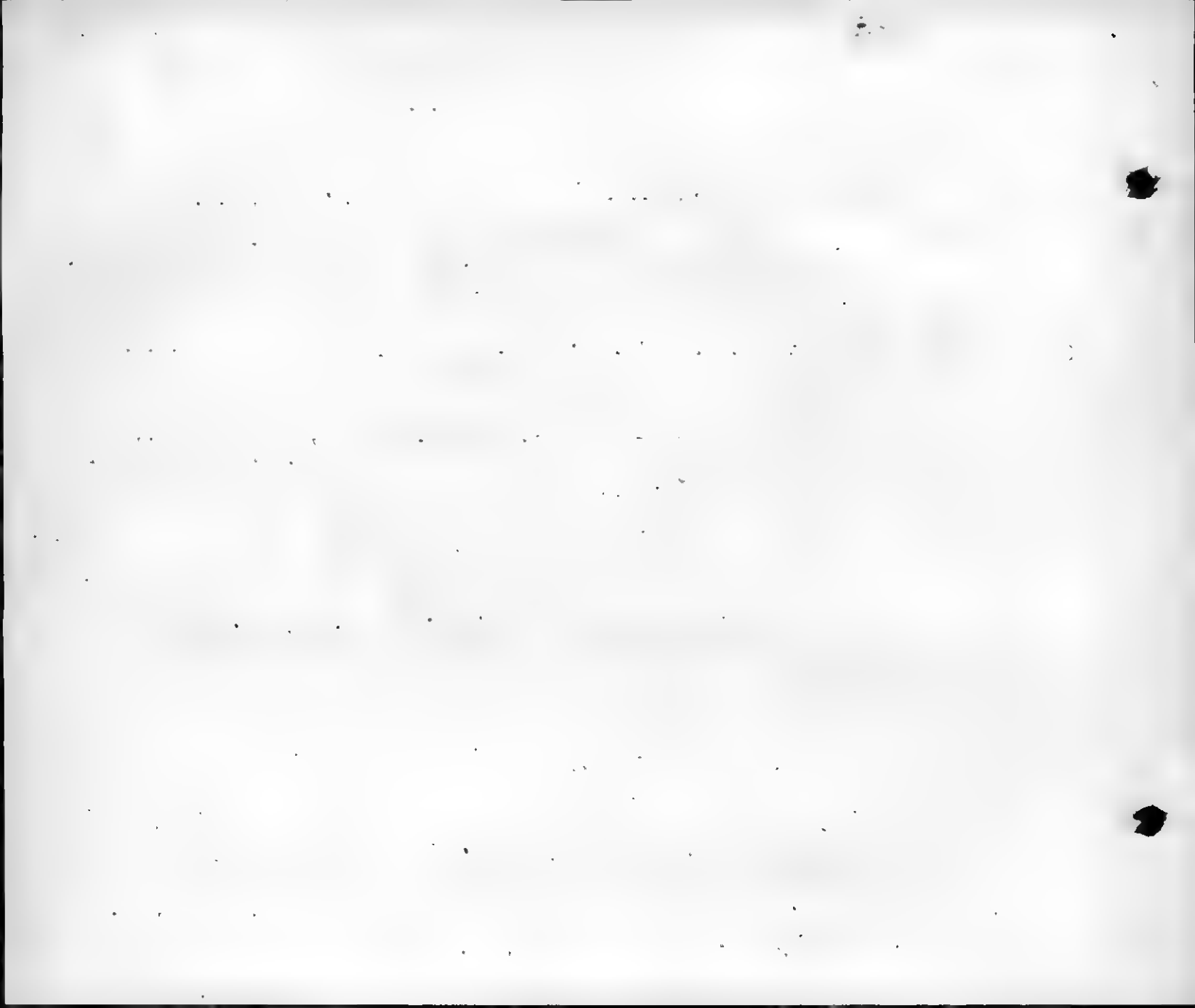
09230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN lb <b>2 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS REST HOME</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>5521 COLORADO AVENUE, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George F. Tarch</b> First Middle Last 4. DATE OF DEATH <b>XX 8 31 1959</b> Month Day Year		5. SEX <b>m</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>8/18/68</b> 9. AGE (In years last birthday) <b>91</b> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Draftsman - U. S. Gov't. War Dept.</b> 11. BIRTHPLACE (State or foreign country) <b>New York State</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB FRECH, Theobald</b> 14. MOTHER'S MAIDEN NAME <b>ELIZABETH Satler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>579-20-2719</b> 17. INFORMANT <b>Mrs. Marie F. Hopkins, 814 Rowen Rd., Silver Spring, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Congestive failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis due to obstructive uropathy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>5 days</b> <b>10 yrs approx</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1959, to <b>August 31, 1959</b> that I last saw the deceased alive on <b>August 31, 1959</b> and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8641- Lakesville Road Aug 31, 59</b> DATE SIGNED ACTUAL SIGNATURE <b>Joseph P. Patten M.D.</b> PHYSICIAN'S NAME (Type) <b>RALPH F. PATTEN M.D.</b> <b>Silver Spring Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>9/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL MAUSOLEUM</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SEP 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

9283

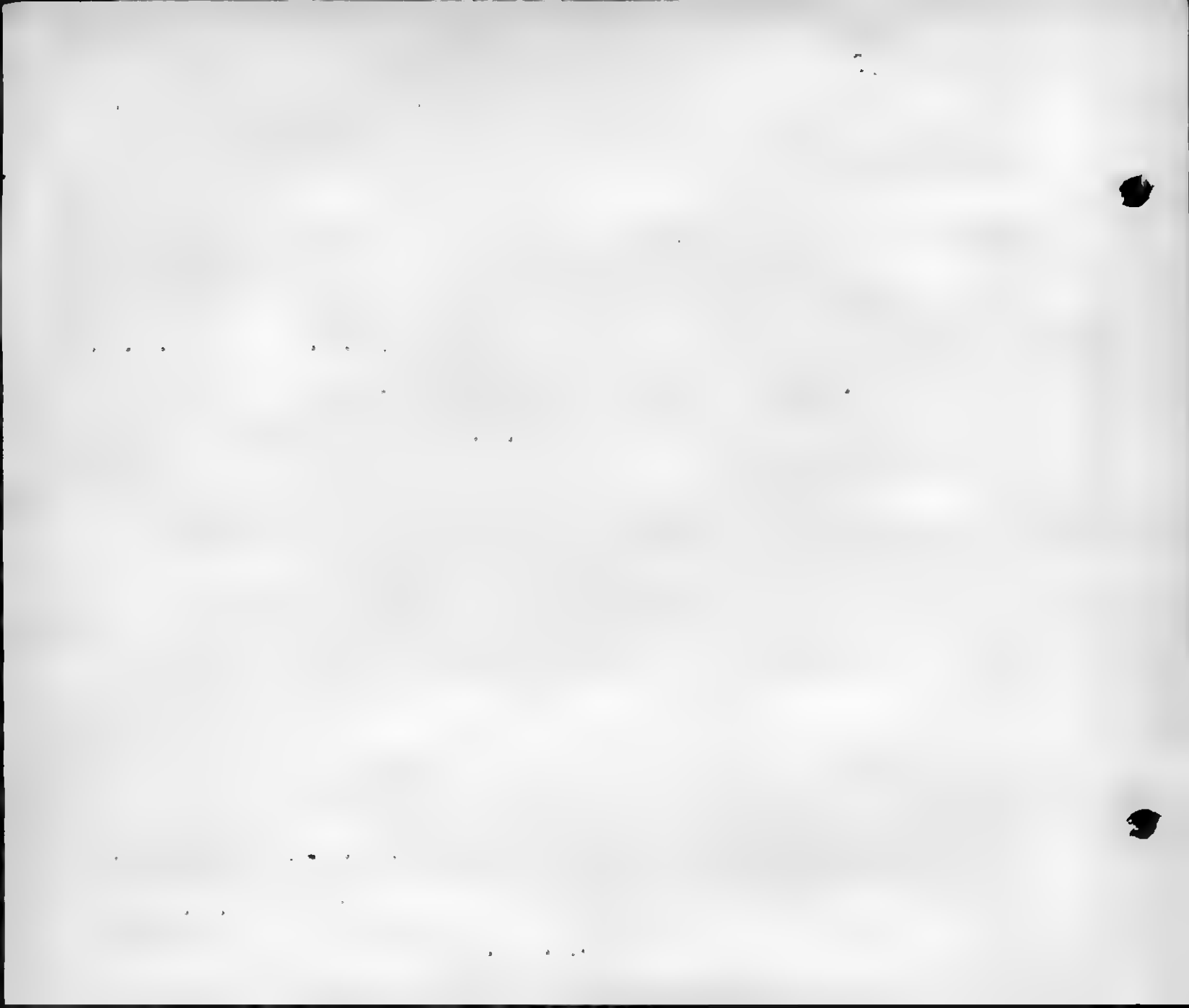
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09231

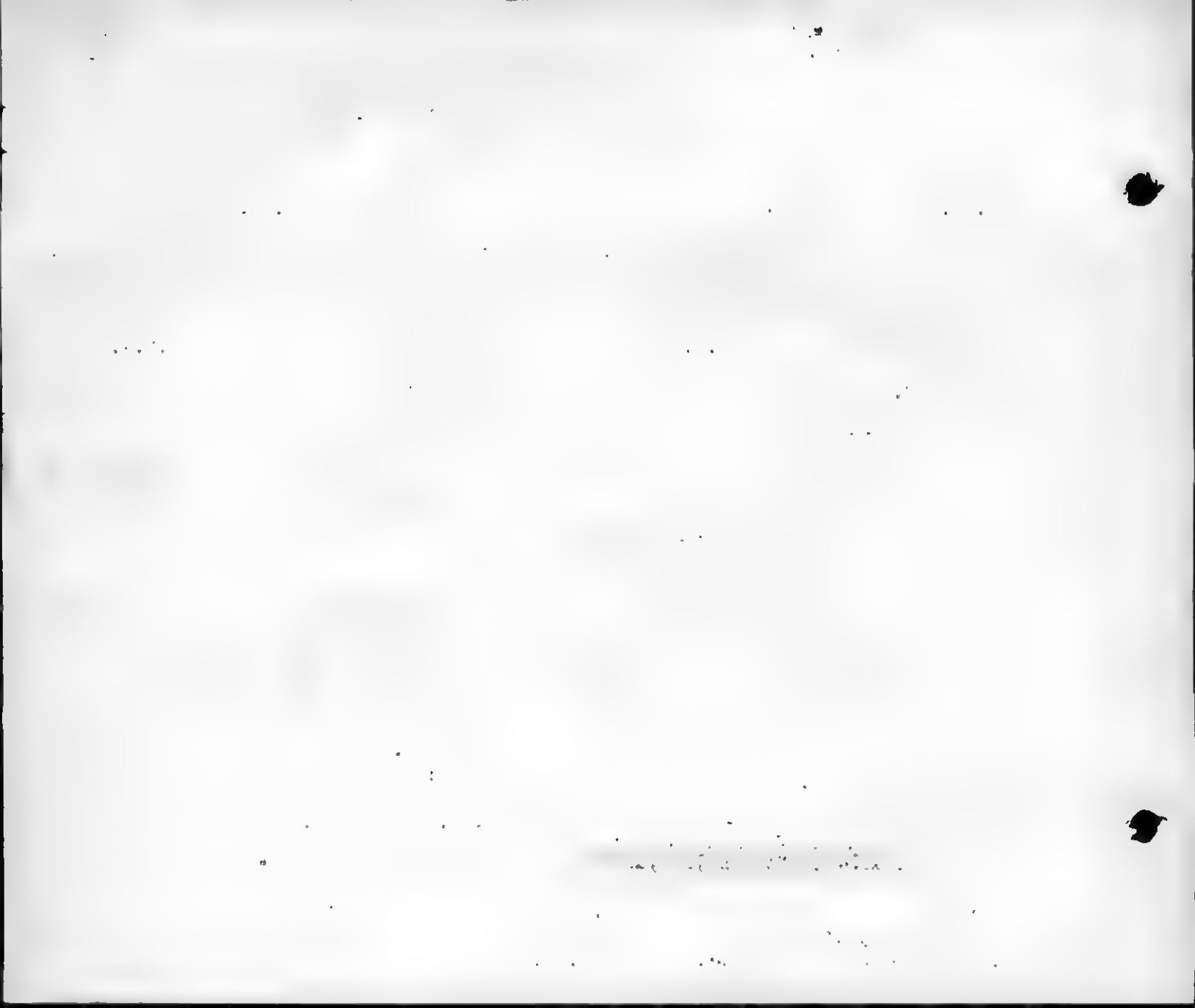
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summer near Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summer near Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5104 Westpath Way</b>		d. STREET ADDRESS <b>5104 Westpath Way</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>M'liss</b> Last <b>Freeman</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1888</b>
9. AGE (In years last birthday) yrs <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. FATHER'S NAME <b>Joshua A. Brown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joshua A. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Marian S. Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Robt. L. Freeman</b>		Address <b>5104 Westpath Way (Summer)</b>	
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Approx 3 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m p m f9		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 Aug 19 59</b> to <b>28 Aug 19 59</b> , that I last saw the deceased alive on <b>28 Aug 19 59</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1746 K St., N. W., Washington, D. C.</b> DATE SIGNED <b>29 Aug 59</b>			
ACTUAL SIGNATURE <b>Clyde P. Reeves</b>		M. D. <b>1746 K St., N. W., Washington, D. C.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Buchs</b>		ADDRESS <b>3034 M St., N.W., D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
9284										
09232										
Reg. Dist. No. 215										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>501 Seward Square, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Cleo</b> Last <b>FREEMAN</b>					4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 59</b>					
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Caucasian</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>12-14-93</b>					
9. AGE (In years last birthday) <b>65</b> yrs					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>					
11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert E. FREEMAN</b>					14. MOTHER'S MAIDEN NAME <b>Alice DURAM</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>					
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chorea, progressive chronic</b> <b>355X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>August 13</b> , 19 <b>59</b> , to <b>August 21</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-22-59</b> ACTUAL SIGNATURE <b>R. L. Christy</b> PHYSICIAN'S NAME (Type) <b>R. L. CHRISTY, CAPT, MC, USN</b> <b>Bethesda 12, Maryland</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-26-59</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Mattingly</b> ADDRESS <b>R. A. Mattingly Funeral Home, 131 11th St. SE, WDC</b>						24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		





**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS 15C 1-55 10M

9285

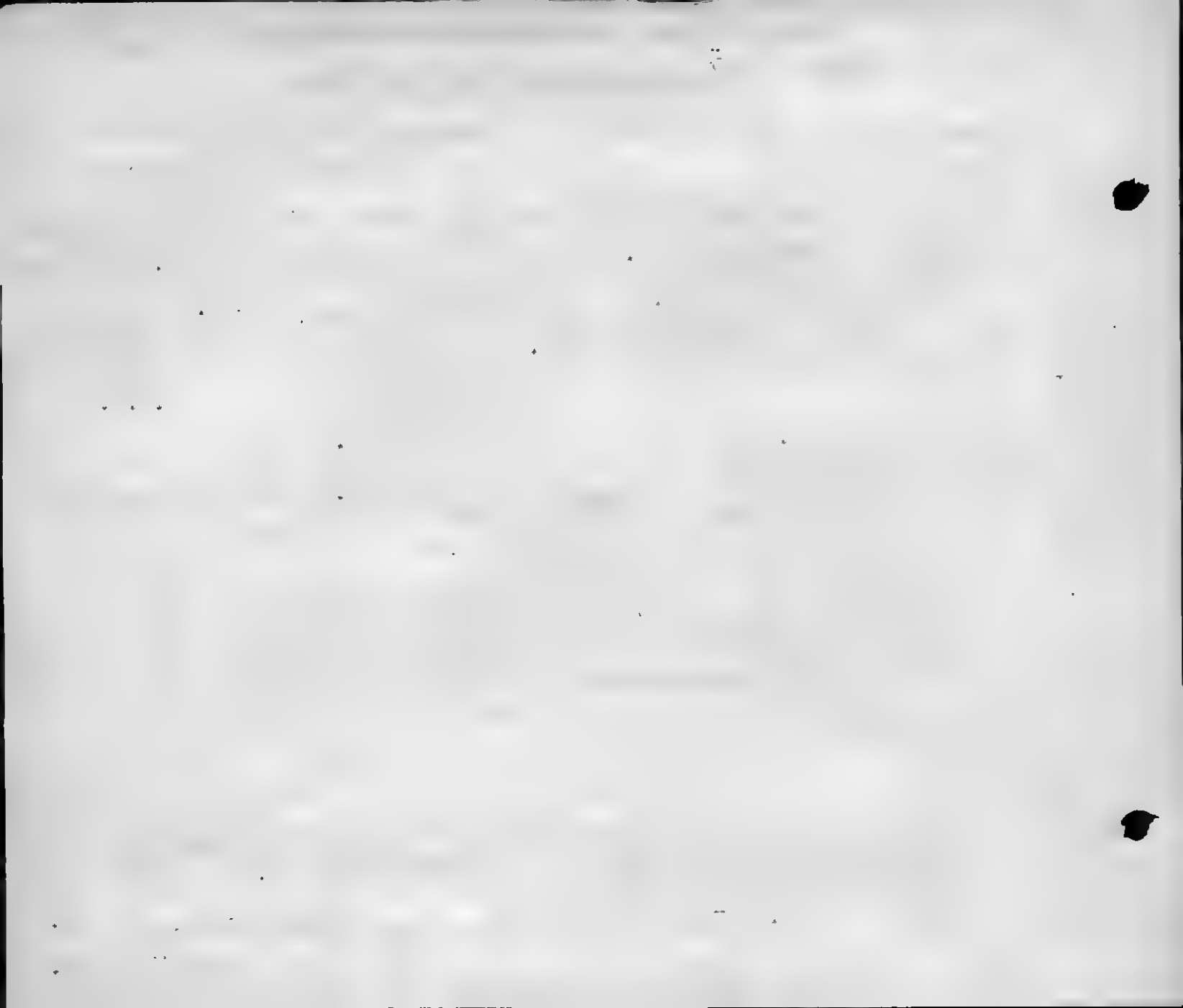
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09233

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Laytonsville</b> LENGTH OF STAY (in this place) <b>50 years</b> TOWN <b>Rural Laytonsville</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Gaithersburg Rt. #1</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Montgomery</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Laytonsville</b> TOWN <b>Rural Laytonsville</b> STREET ADDRESS (If rural give location) <b>Gaithersburg Rt. #1 Lived on Farm</b>			
3. NAME OF DECEASED (Type or Print) (First) <b>William</b> (Middle) <b>H.</b> (Last) <b>Fulks</b>				4. DATE OF DEATH (Month) <b>Aug.</b> (Day) <b>5</b> (Year) <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Jan. 8 1878</b>	9. AGE last birthday <b>81</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Fulks</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS <b>John P. Fulks Bethesda, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Arteriosclerotic Heart Disease as manifest by Congestive Heart Failure.</b>						<b>10 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>by Congestive Heart Failure.</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug. 4, 19 59</b> to <b>Aug. 5, 19 59</b> , that I last saw the deceased alive on <b>Aug. 4, 19 59</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Jack Schumacher</b> M.D.				ADDRESS (Street, city, town, state) <b>Gaithersburg, Md.</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 8 -59</b>		NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>	
24. REC'D BY REGISTRAR <b>AUG 10 '59</b>		REGISTRAR'S SIGNATURE <b>Charles E. House</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>			



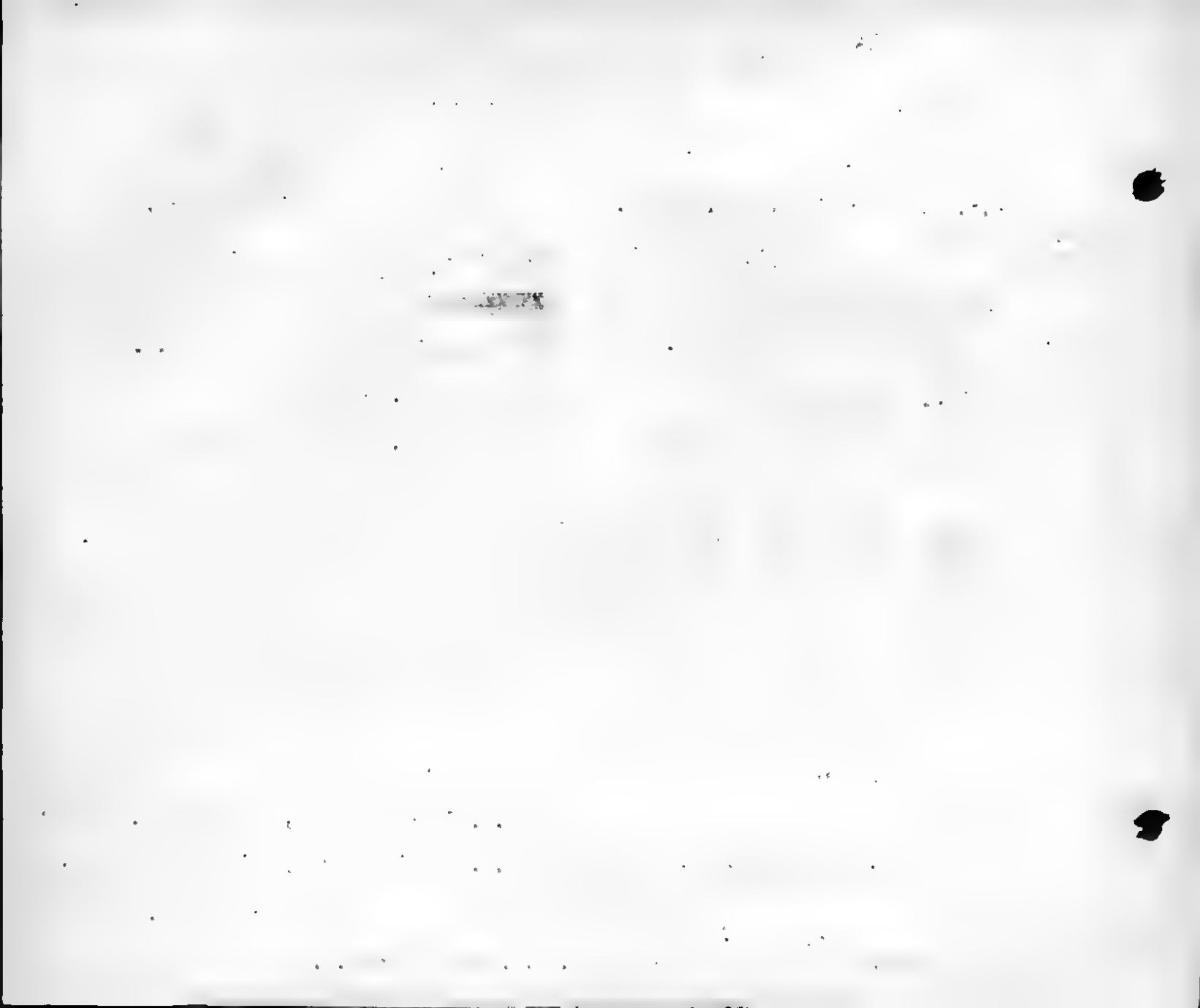
09234

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Virginia</b>		b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		d. STREET ADDRESS <b>304 Courtney Drive Thompson Pk.</b>					
3. NAME OF DECEASED (Type or print) <b>Regina Ellen GALICZYNSKI</b>		First Middle Last		4. DATE OF DEATH <b>August 1 19 59</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-18-59</b>		9. AGE (In years last birthday) <b>2</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Carl J. GALICZYNSKI</b>				14. MOTHER'S MAIDEN NAME <b>Lillian T. KRUPA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(Father) Carl J. GALICZYNSKI Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>Multiple Congenital Anomalies</b>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.1</b> DUE TO (b) <b>limb-saliv, single, left; Cleft palate, anterior</b> (c) <b>limbosacral; Calcaneo-valgus deformity; Patent ductus arteriosus, large; interventricular</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>septal defect; and many other deformities</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 July</b> , 19 <b>59</b> , to <b>1 August</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1 August</b> , 19 <b>59</b> , and that death occurred at <b>2:45P</b> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <b>D. Harris</b>				DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 8-3-59</b>			
PHYSICIAN'S NAME (Type) <b>D. HARRIS, LT, MC, USN</b>				U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest A. Adams</b> ADDRESS <b>ADAMS Funeral Home 4748 Wisconsin Ave. N.W. Washington D.C. '59</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

AUG 6 '59

Ernst L. Krenz



9210

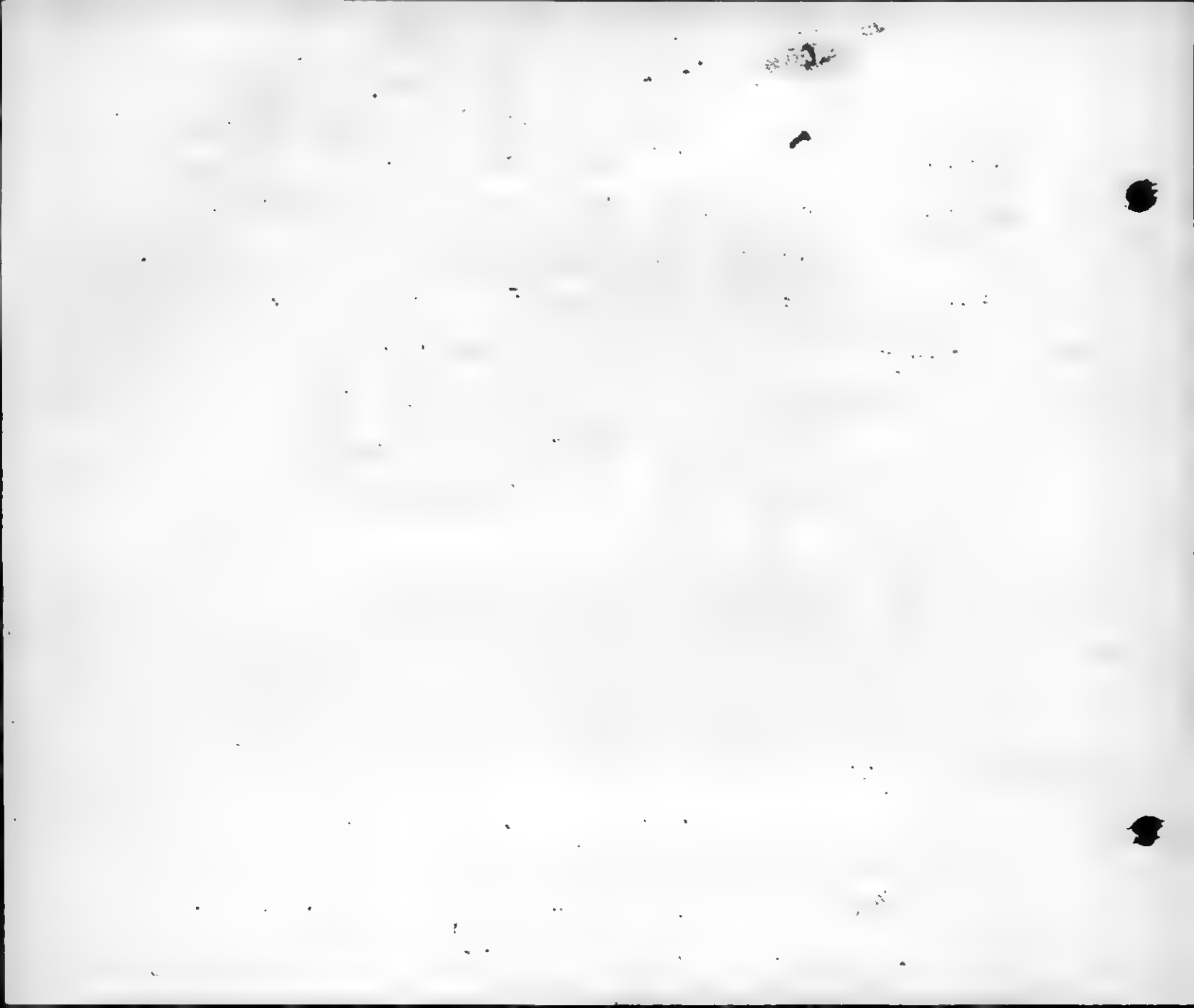
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN lb <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>11007 Amherst Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>FRIMA</u> Middle <u>(NMN)</u> Last <u>GARBER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/95</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswnf.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>DORIS</u>				14. MOTHER'S MAIDEN NAME <u>MINERVA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>577-03-1406</u>		INFORMANT <u>PH's Hosp. Record</u> Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach with metastases</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>about 7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>59</u> , to <u>8/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>				ADDRESS (Street, city or town, state) <u>M.D. 7733 Alaska Ave. N.W. Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON</u>				DATE SIGNED <u>8/26/59</u>			
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF <u>8/28/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DC Lodge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cockey Funeral Home</u> ADDRESS <u>4717-9th Ave</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>AUG 28 '59</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9287

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>3717 Underwood St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>St. Clair</b> Last <b>Jr. or</b>				4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>19</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/1895</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles H. Gardiner</b>				14. MOTHER'S MAIDEN NAME <b>Louise Saintclair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>41</b>		17. INFORMANT <b>Wm. S. Gardiner Jr.</b> Address <b>Item 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>History of previous heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>Wash. D.C. 3821 14th. St. N. W.</b>				24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.





9288

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

119237

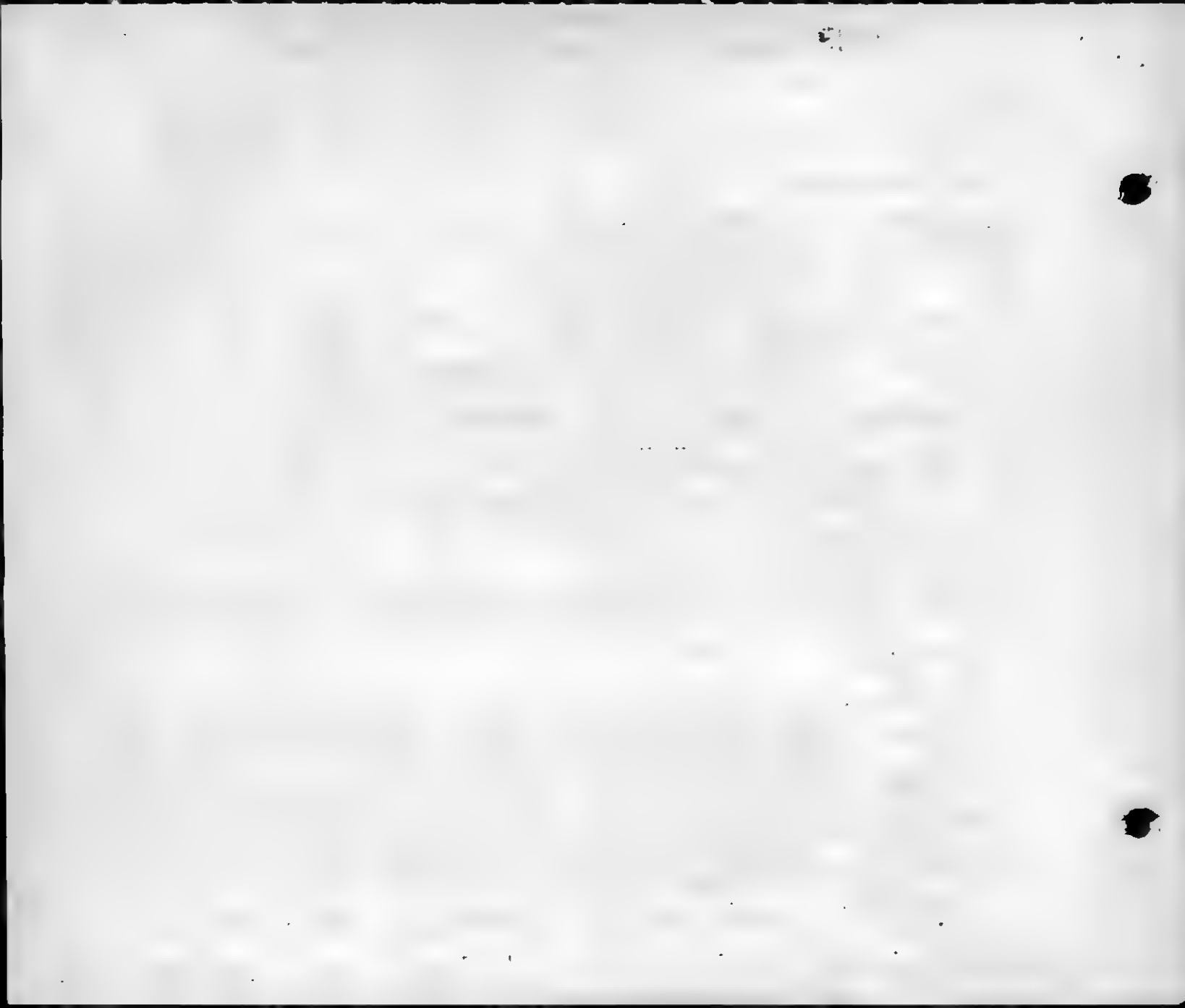
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Shawnee</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Topeka</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>POPLAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10225 Green Forest Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Walter Geyer</u>		4. DATE OF DEATH <u>Aug 11 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1881</u>
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kan.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kan.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Geyer</u>		14. MOTHER'S MAIDEN NAME <u>Helene Zables</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>510-16-8860</u>	
17. INFORMANT <u>Ethel Geyer (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u> sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>8/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Topeka, Kansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 14 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kane</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09238

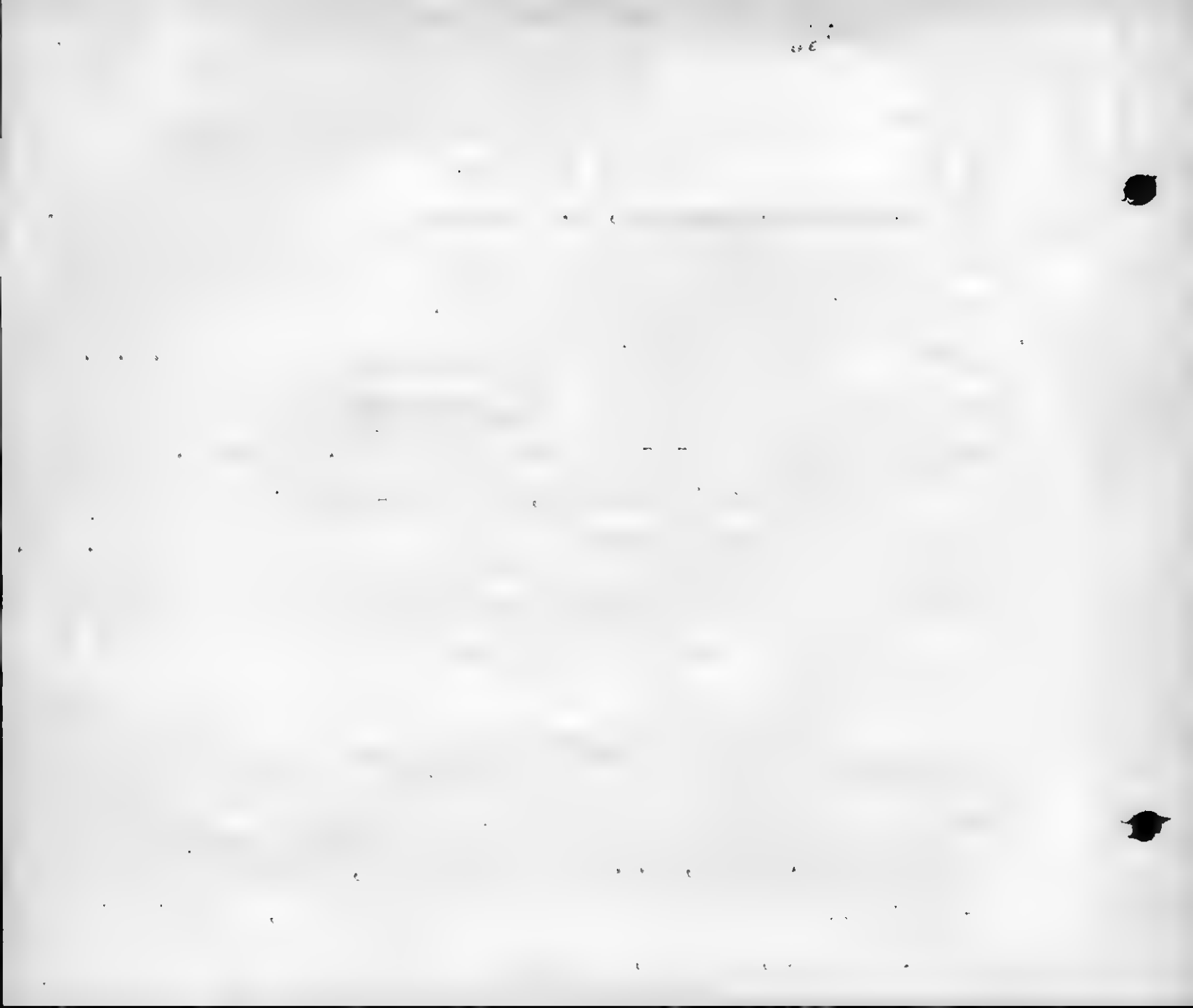
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>128 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) a. STATE <b>West Virginia</b> b. COUNTY <b>Watson</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1</b> d. STREET ADDRESS <b>Route 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cecil James Gibson</b>				4. DATE OF DEATH Month Day Year <b>August 5, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1932</b>	
9. AGE (In years last birthday) yrs. <b>27</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>27</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Claude Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Slone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>235-54-2022</b>		17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Massive Hemorrhage, Intotracheo-Broncheal Tree</b> DUE TO (b). <b>Acute Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>less than 30 Minutes</b> <b>Approx. 1 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 30</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>11:40 P</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 8/6/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Arthur R. Rothman</b>		M.D. <b>ARTHUR R. ROTHMAN, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>8/7/1959</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Fairmont, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumpfrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



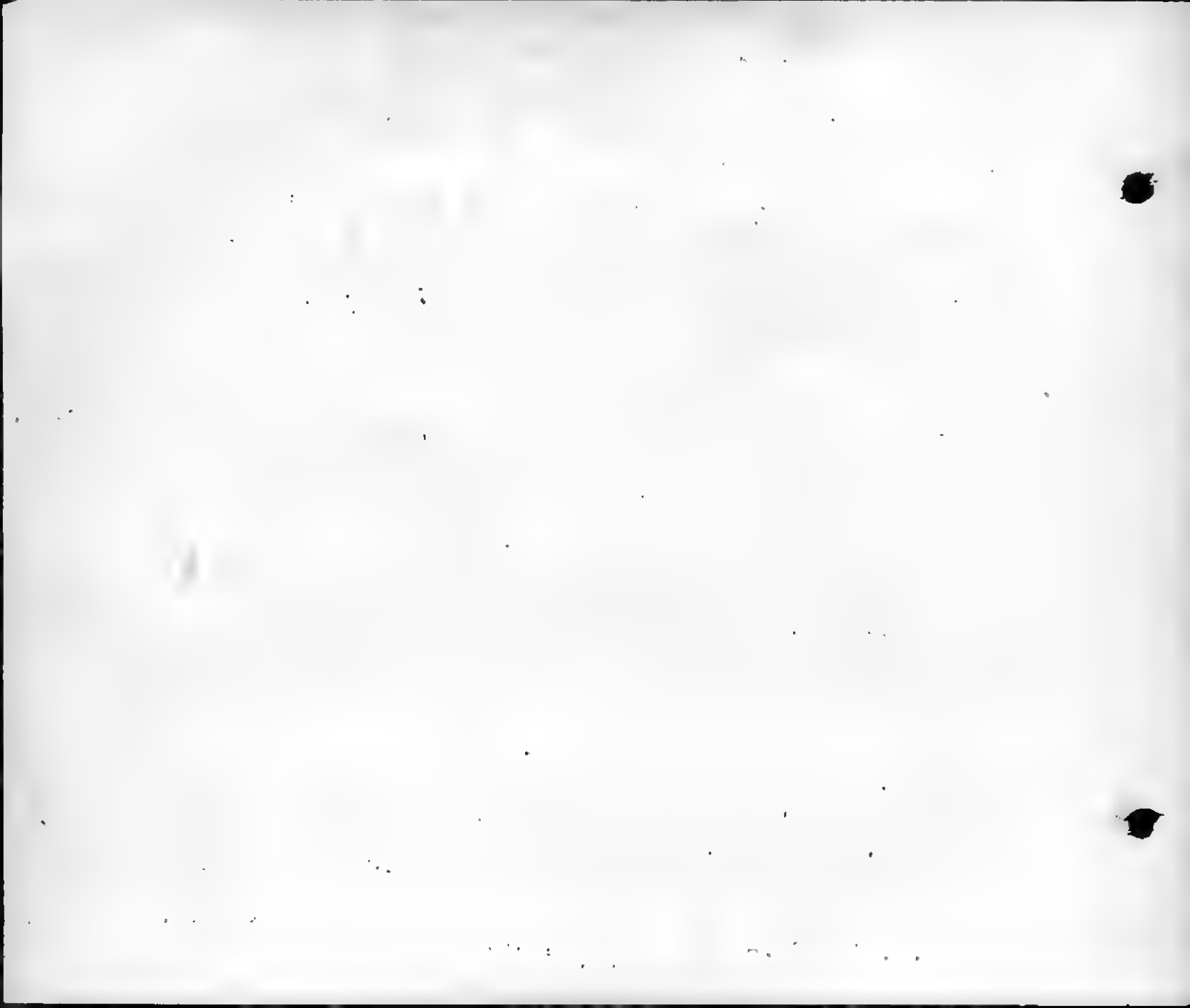
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9290  
CERTIFICATE OF DEATH

Reg. Dist. No.

09239

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x</u>	
c. LENGTH OF STAY IN lb <u>2 yrs 9 mo. 7 days</u>		d. STREET ADDRESS <u>2651-16<sup>th</sup> St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lida A Gilbert</u>		4. DATE OF DEATH Month Day Year <u>8 1 1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1859</u>
9. AGE (In years last birthday) <u>100</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houswife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Clements</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>LOUIS P. HILWINE</u>		Address <u>Rockville, Md. 1144 Rockwell Pkwy.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, broncha-</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>left inguinal hernia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>40 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>31 July</u> , 19 <u>59</u> , to <u>1 AUG</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 AUG</u> , 19 <u>59</u> , and that death occurred at <u>8:32 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Wyman</u> M.D.		ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd.</u> DATE SIGNED <u>8-1-59</u>	
PHYSICIAN'S NAME (Type) <u>John M. Wyman MD.</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>AUG 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



9291

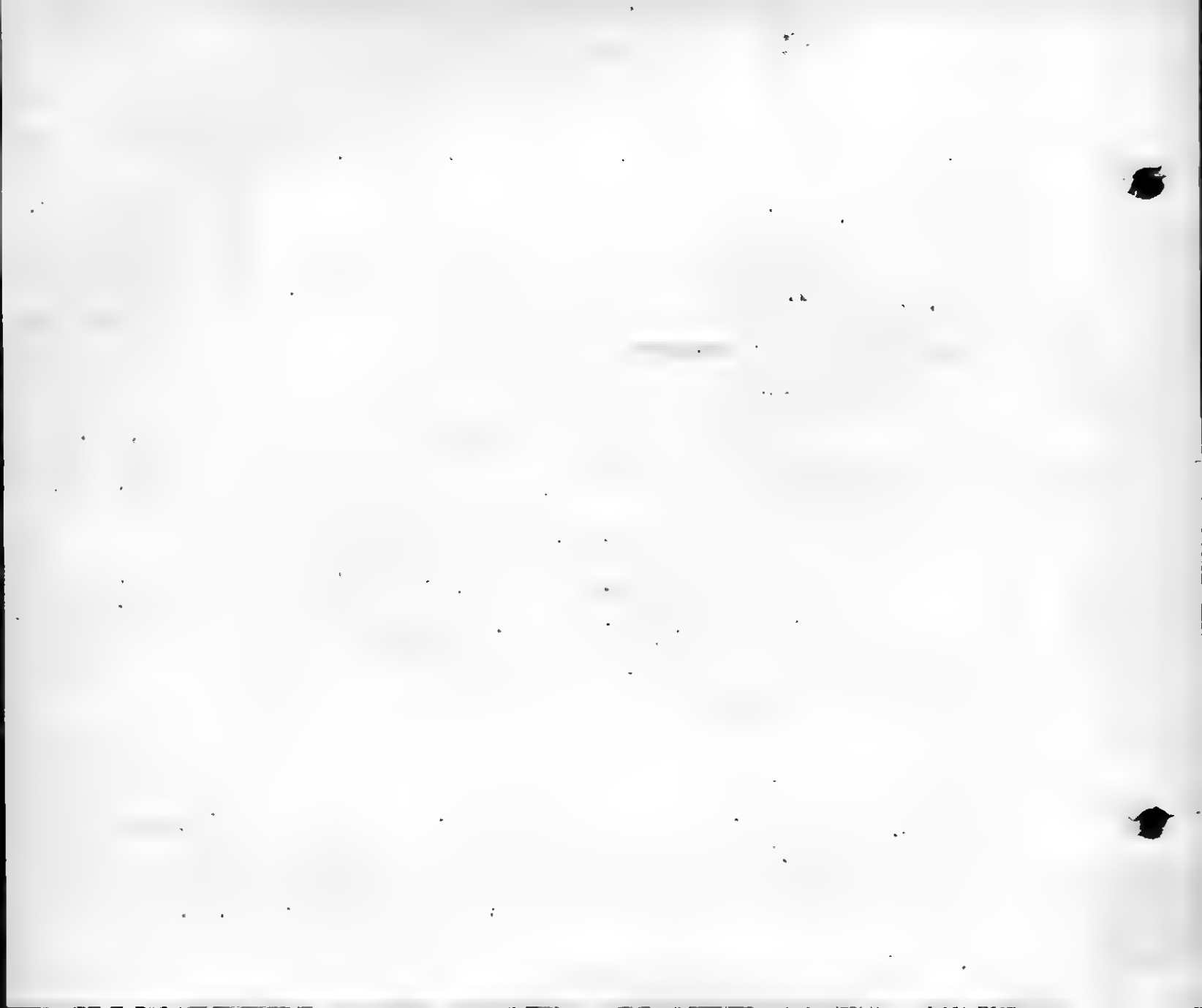
CERTIFICATE OF DEATH

05240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd Md</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Buck Lodge Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Glover</b> Last <b>Glover</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) yrs <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Greenkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Glover</b>		14. MOTHER'S MAIDEN NAME <b>Martha Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Margaret L Heard</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic glomerulonephritis</b> DUE TO <b>Chronic glomerulonephritis</b> (c) <b>Chronic glomerulonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 months</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes - 10 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Washington D. C.</b>	
21. I certify that I attended the deceased from <b>Sept 19 58</b> to <b>16 Aug 1959</b> , that I last saw the deceased alive on <b>14 Aug 1959</b> , and that death occurred at <b>3:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boyd, Md 16 Aug 59</b> DATE SIGNED ACTUAL SIGNATURE <b>John E. Fawcett</b> M.D. <b>Boyd, Md 16 Aug 59</b> PHYSICIAN'S NAME (Typed) <b>JOHN E. FAWCETT M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		24. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9292

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene</u> First <u>Harold</u> Middle <u>Gough</u> Last		4. DATE OF DEATH <u>8</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Deputy Controller of Currency U.S. Gov. Indiana</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Gough</u>	
14. MOTHER'S MAIDEN NAME <u>Ida M. Rogers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. ADDRESS <u>James H. Gough - Son - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO (b) <u>Captured aneurysm, left Anterior Communicating Artery</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/19/59</u> to <u>8/19/59</u> , that I last saw the deceased alive on <u>8/19/59</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Tuohy</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY</u>		<u>7720 Wisconsin Ave., Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Boonville, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co.</u> ADDRESS <u>2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Walter S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9293

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09242

## CERTIFICATE OF DEATH

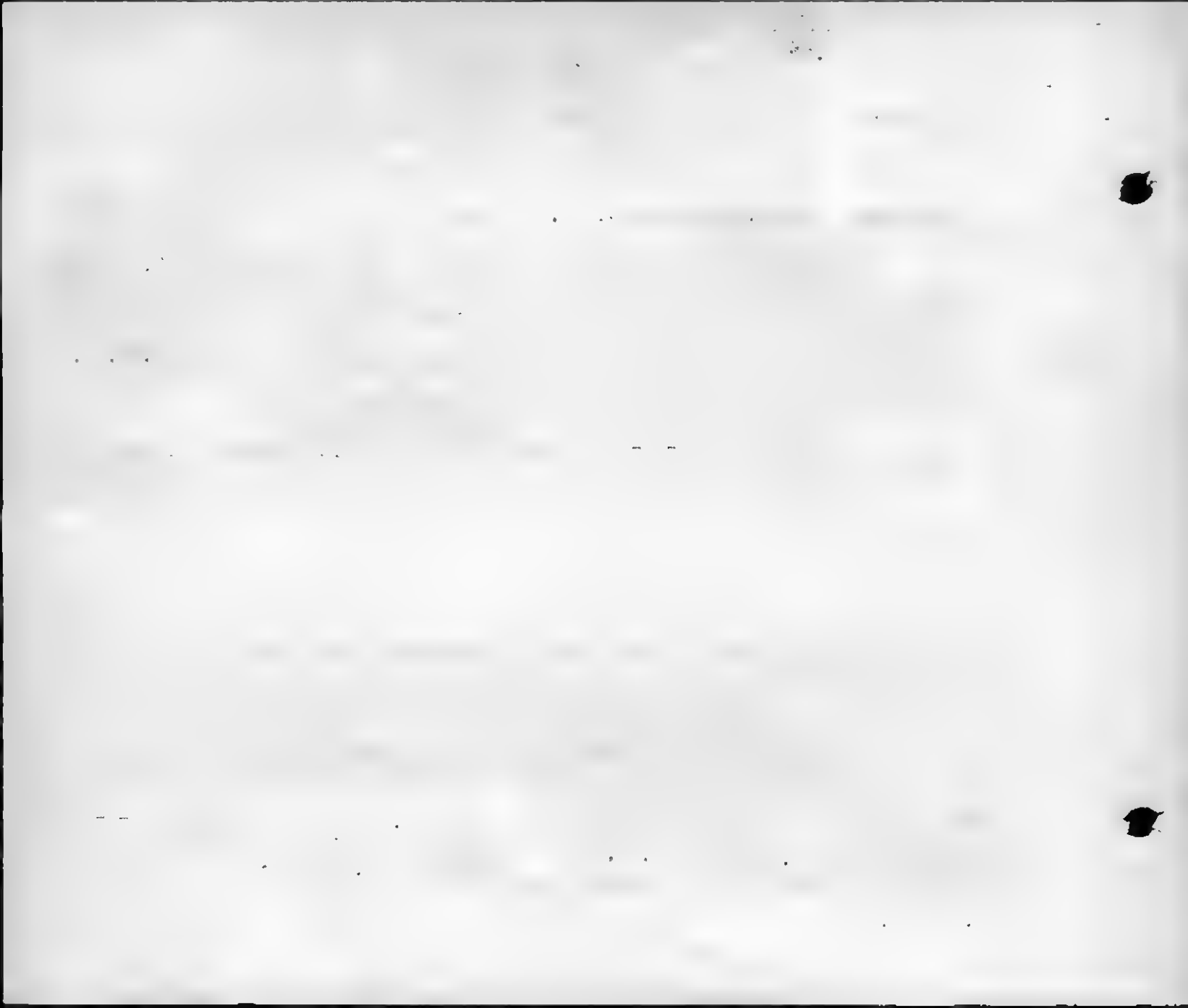
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>151 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY <b>Lix 3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tylertown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nercellia Evelyn Grubbs</b>		4. DATE OF DEATH Month Day Year <b>August 3, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Payne</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>427-48-9796</b>	
17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 42 DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Subendocardial Myocardium</b> DUE TO <b>Refractory anemia (compensated)</b> (c) <b>Hemiparesis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b> <b>2 weeks</b> <b>5 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 19 59</b> to <b>August 3, 19 59</b> , that I last saw the deceased alive on <b>August 3, 19 59</b> , and that death occurred at <b>11:40 P.</b> M., from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
ACTUAL SIGNATURE <b>Arthur I. Grayzel</b> M.D. NAME (Type) <b>Arthur I. Grayzel, M. D.</b>		DATE SIGNED <b>8-4-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>8/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Tylertown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tylertown, Mississippi</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9211

CERTIFICATE OF DEATH

09243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institut an. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>4 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7401 GARLAND AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE LEE GUNDERSON</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 29 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/92</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Burroughs Company</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. GUNDERSON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH TOLSFSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>184-01-1583A</b>	
17. INFORMANT <b>Mrs. Georgia S. Gunderson, 7401 Garland Ave. Takoma Park, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Metastases to Liver, Pancreas, &amp; Abdominal wall</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1942</b> to <b>Aug 29, 1959</b> that I last saw the deceased alive on <b>Aug 29, 1959</b> and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W B Wardrop MD</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>837 Bond St Baltimore Md 9/29/59</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM B. WARDROP</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Mem. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9212

CERTIFICATE OF DEATH

Reg. Dist. No.

09244

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <i>Penna.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pottsville</i>	
c. LENGTH OF STAY IN lb <i>4 days</i>		d. STREET ADDRESS <i>RD 3 (WADE)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edith</i> First <i>None</i> Middle <i>Male</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-87</i>
9. AGE (In years last birthday) <i>71</i> yrs		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>EDUCATION</i>	11. BIRTHPLACE (State or foreign country) <i>Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Elisha Smith</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Williams</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service; -----)	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Washington Sanitarium &amp; Hospital Pottsville</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>151X</i> DUE TO <i>Carcinoma Stomach</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>3 years.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 27, 1959</i> to <i>August 26, 1959</i> , that I last saw the deceased alive on <i>Aug 26</i> <i>1959</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lyle Williams</i> M.D.		ADDRESS (Street, city or town, state) <i>8700 Bloomsburg Rd - Schuylkill</i> DATE SIGNED <i>Aug 26, 1959</i>	
PHYSICIAN'S NAME (Type) <i>Lyle Williams</i>			
22a. BURIAL, CREMATION, REMOVA. (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/26/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Pottsville, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>1756 Penna. Ave. NW, D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE AUG 31 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00-22



9294

## CERTIFICATE OF DEATH

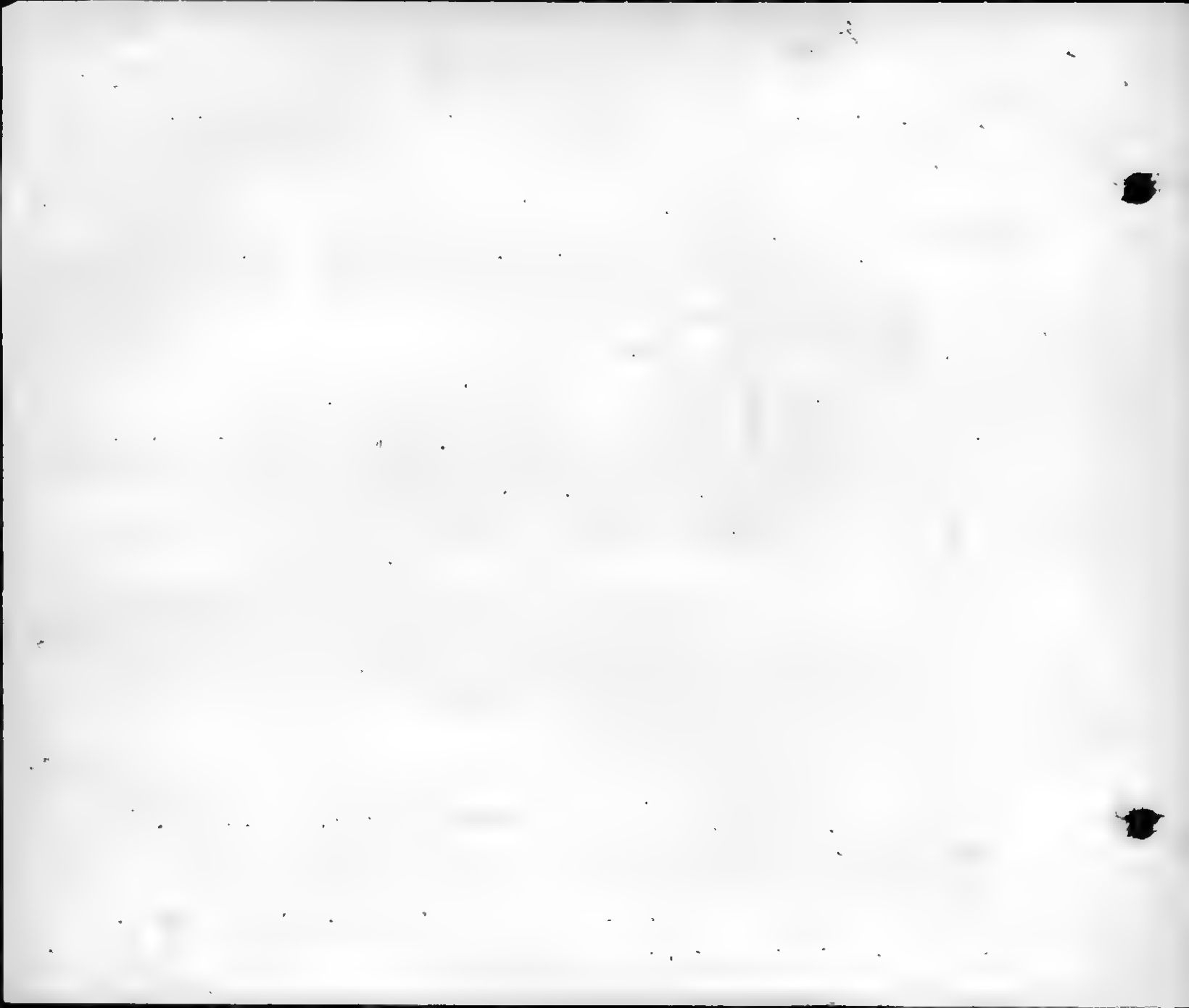
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 hr 29 min 16</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1d. STREET ADDRESS <u>1912 HENRY ROAD</u>							
3. NAME OF DECEASED (Type or print) <u>MARK First</u> <u>INFANT (MALE)</u> Middle <u>Hamernik</u> Last <u>Hamernik</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/23/59</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>		11. IF UNDER 24 HRS Hours <u>1</u> Min. <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Daniel J Hamernik</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Sokol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>Daniel J. Hamernik-father-item 2d</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Innaturity + Prematurity</u>							
DUE TO (b) <u>Premature delivery - 22 wks</u>							
DUE TO (c) <u>15 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/23</u> , 19 <u>59</u> , to <u>8/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/23</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph C. O'Neil</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Rockville, Md. Center</u>			
PHYSICIAN'S NAME (Type) <u>Joseph C. O'Neil</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Carmel, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074352XV6



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9295

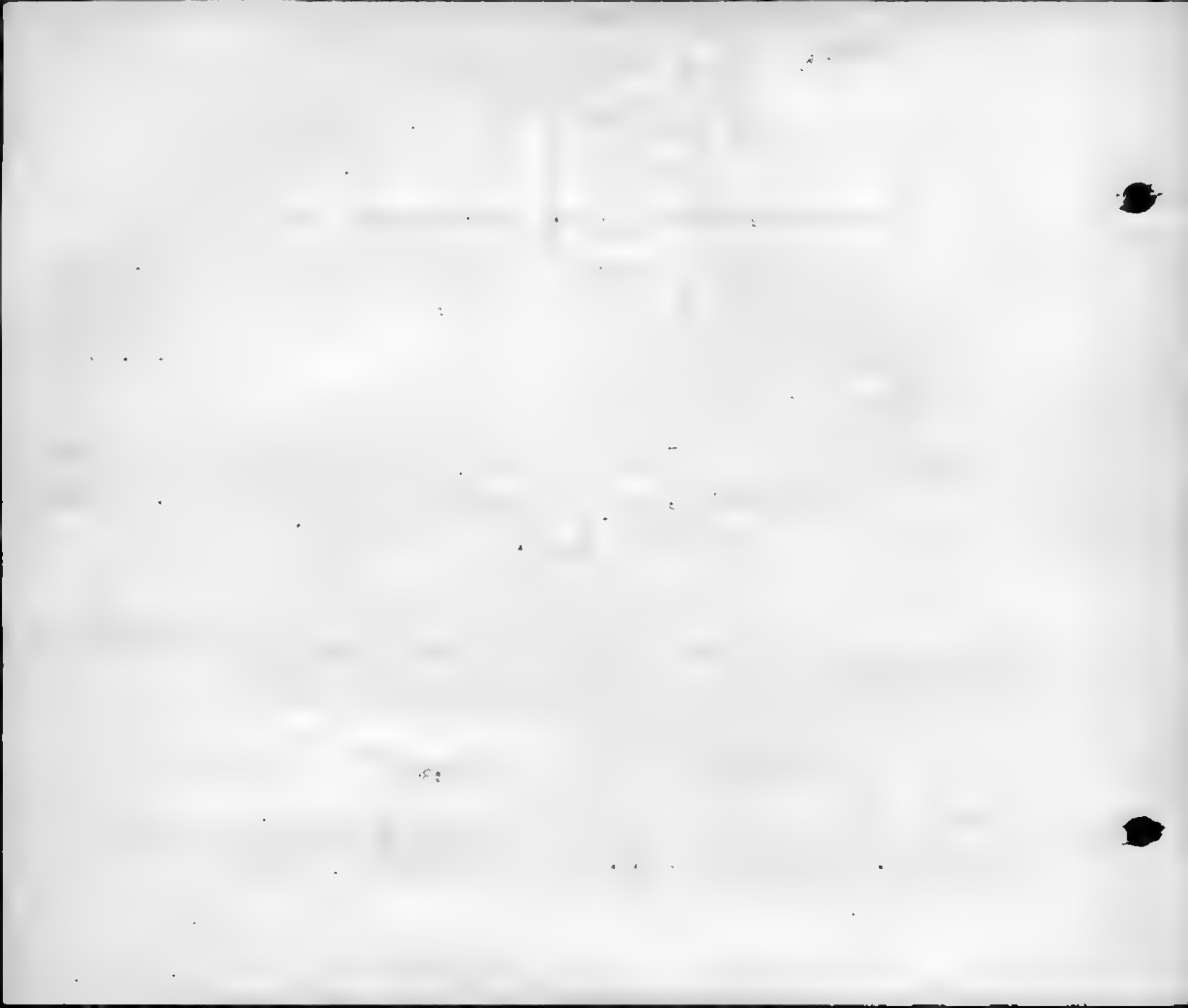
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>19X 3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Elmhurst, Long Island</b> d. STREET ADDRESS <b>2718 McIntosh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Esmond</b> Middle <b>Lemond</b> Last <b>Haywood</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1936</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Marine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ben Haywood</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>191-30-8021</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure in Postoperative Period following correction of Tetralogy of Fallot.</b> 7-4-0 DUE TO <b>Congenital Cyanotic Heart Disease, Tetralogy of Fallot.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>23 Years</b> (c) <b>23 Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 7, 19 59</b> to <b>August 28, 19 59</b> , that I last saw the deceased alive on <b>August 28, 19 59</b> , and that death occurred at <b>7:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>N. Perryman Collins</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/29/59</b>	
PRINTED NAME (Type) <b>N. Perryman Collins, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>9-1-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier Funeral Home</b>		ADDRESS <b>389-R.T. Ave. NW</b>	
24a. REC'D BY REGISTRAR <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneas</b>	



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

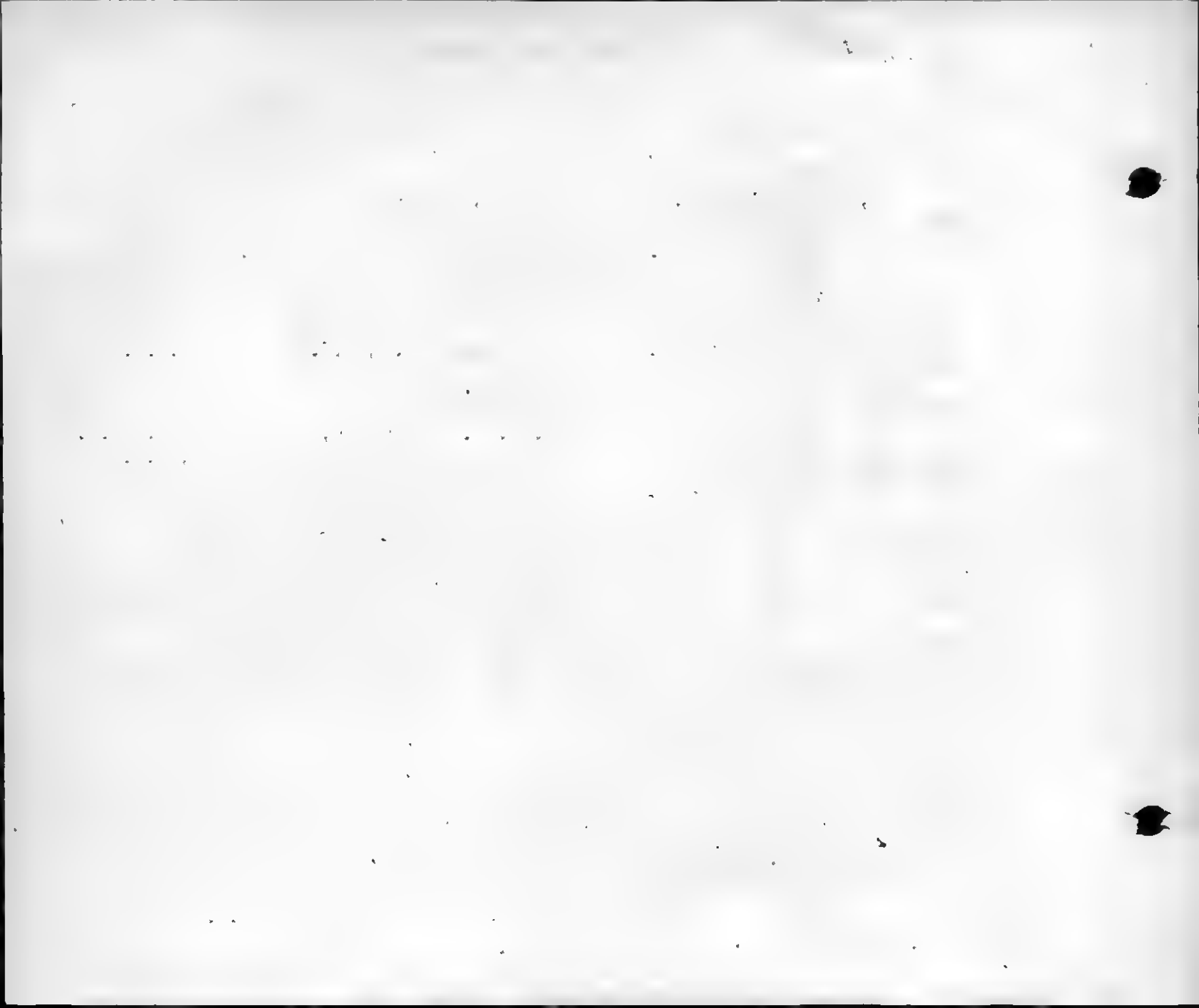
## 9296

### CERTIFICATE OF DEATH

09247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>26 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,213 GEORGIA AVE.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>10,213 GEORGIA AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNA</b> Middle <b>E.</b> Last <b>HEITMULLER</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/70</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER - OWN HOME - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SPENGLER</b>		14. MOTHER'S MAIDEN NAME <b>OTELIA KRAFT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. T. L. Heitmuller, 3001 Beech St., N.W.</b>		Address <b>Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>1 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO <b>15 years</b> (c) <b>Generalized Arteriosclerosis</b> DUE TO <b>30 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1958</b> to <b>Aug 13, 1959</b> that I last saw the deceased alive on <b>Aug 13, 1959</b> and that death occurred at <b>2:39 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>8/13/59</b>			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
22e. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>Raymond A Ziska</b> DATE <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09248**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8662 Piney Branch Rd</u>				d. STREET ADDRESS <u>8662 Piney Br. Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>T.</u> Middle <u>Robert</u> Last <u>Henriques</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-1958</u>	
9. AGE (In years last birthday) yrs. <u>10</u> Months <u>7</u> Days <u>7</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Vito E. Henriques</u>			
14. MOTHER'S MAIDEN NAME <u>Lucinda McCrea</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Lucinda Henriques</u> Address <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Vomiting</u> (c) <u>upper Respiratory Infection</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-21-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Lisk</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

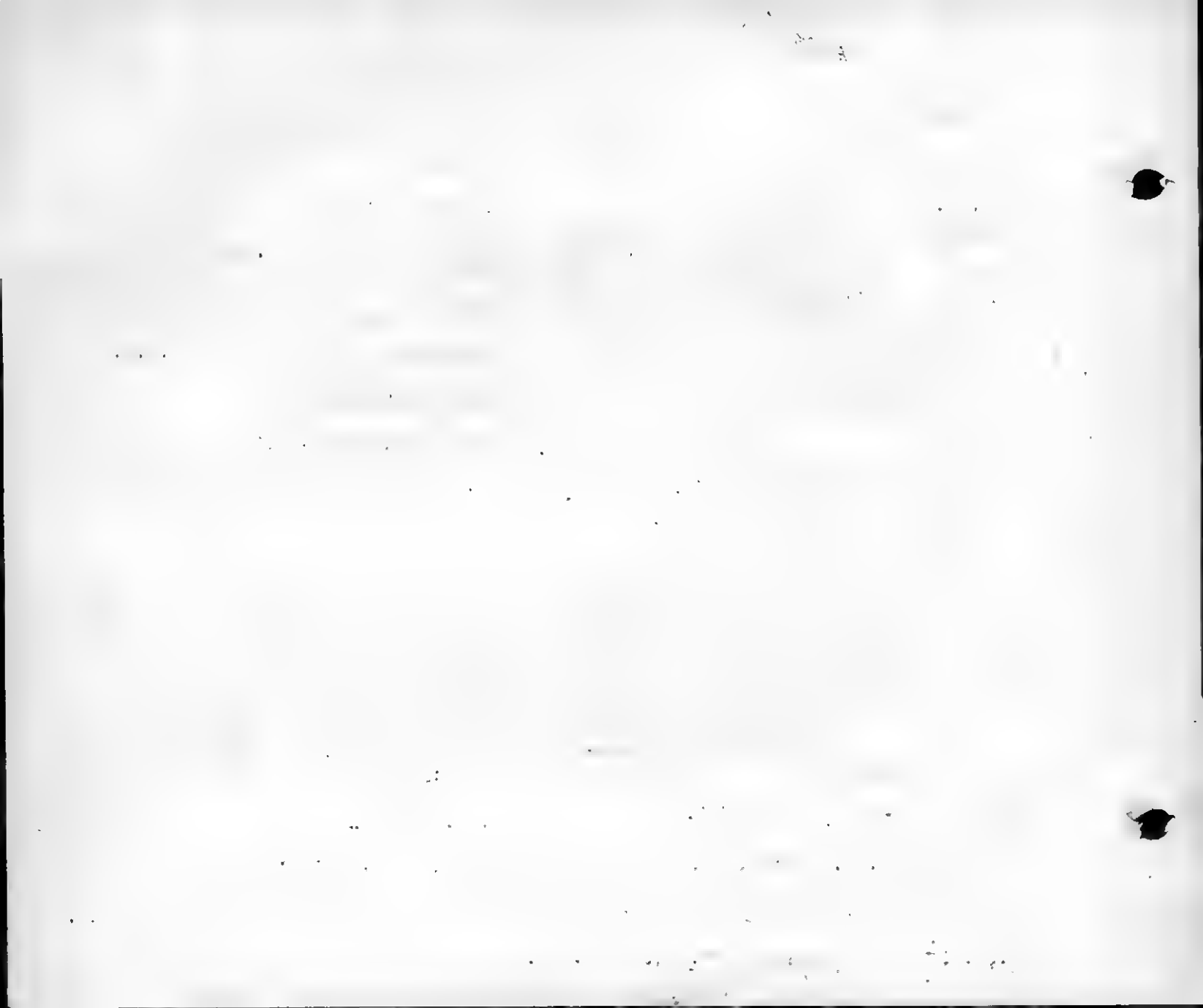




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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09249			
2998										CERTIFICATE OF DEATH			
Reg. Dist. No. 215													
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Y</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b> d. STREET ADDRESS <b>#1 Oakdale Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Darline HILL</b>					4. DATE OF DEATH Month Day Year <b>August 17 19 59</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-59</b>		9. AGE (In years last birthday) yrs Months Days Hours Min <b>15</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>					11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Buster HILL</b>					14. MOTHER'S MAIDEN NAME <b>Margaret CHAMBERS</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(F) Buster Hill, same as #2</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital Heart Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>August 12 19 59</b> to <b>August 17 19 59</b> that I last saw the deceased alive on <b>August 17 19 59</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-18-59</b>													
ACTUAL SIGNATURE <b>H. L. Walton</b> M.D. <b>U. S. Naval Hospital</b>					DATE SIGNED <b>8-18-59</b>								
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT. MC, USN</b>					Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>			22b. DATE THEREOF <b>8-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>LaFollette Tenn.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b> ADDRESS <b>Bethesda, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 19 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9213

CERTIFICATE OF DEATH

09250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>1</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>16 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium &amp; Hosp.</i>				d. STREET ADDRESS <i>200 Hibbard Street</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Gordon</i> Middle <i>Wes</i> Last <i>Hodgins</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>27</i> Year <i>1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/20/43</i>	9. AGE (In years last birthday) <i>15</i> yrs.	10. UNDER 1 YEAR Months <i>15</i> Days <i>15</i> Hours <i>15</i> Min <i>15</i>	11. UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. - American</i>	
13. FATHER'S NAME <i>George W. Hodgins</i>				14. MOTHER'S MAIDEN NAME <i>Lois E. Loney</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Chart (Fathic) 200 Hibbard St.</i>		INFORMANT <i>Chart (Fathic) 200 Hibbard St.</i>		Address <i>Oakton, Virginia</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416X</i> DUE TO <i>Cerebral arrest -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Biphasal vascular collapse</i> DUE TO <i>30 minute</i> (c) <i>Thrombosis of portal vein (Banti's syndrome) 13 yrs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5 minute</i>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 11, 1959</i> to <i>Aug 27, 1959</i> that I last saw the deceased alive on <i>Aug 27, 1959</i> , and that death occurred at <i>1:50 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lyle Williams</i>		M.D. <i>8700 Coleridge Rd.</i>		ADDRESS (Street, city or town, state) <i>8700 Coleridge Rd.</i>		DATE SIGNED <i>8/27/59</i>	
PHYSICIAN'S NAME (Type) <i>Lyle Williams</i>		SIGNATURE <i>Scherbaum, Paul</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-30-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Flint Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Oakton Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Monroe King DML Pickens</i>				ADDRESS <i>Spring La.</i>		24a. REC'D BY REGISTRAR <i>AUG 31 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Christ &amp; Frank</i>			

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

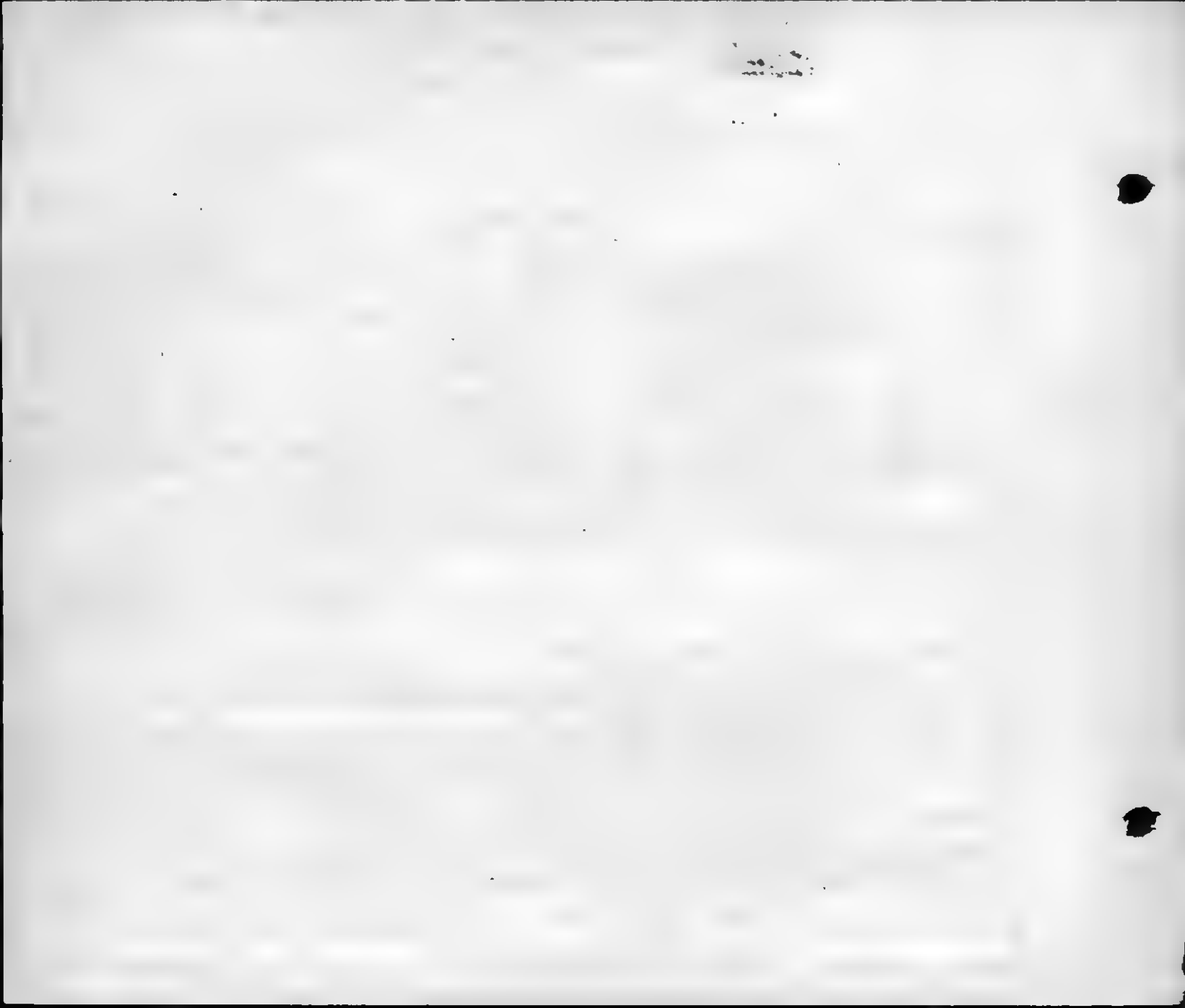
9214

## CERTIFICATE OF DEATH

Reg. Dist. No.

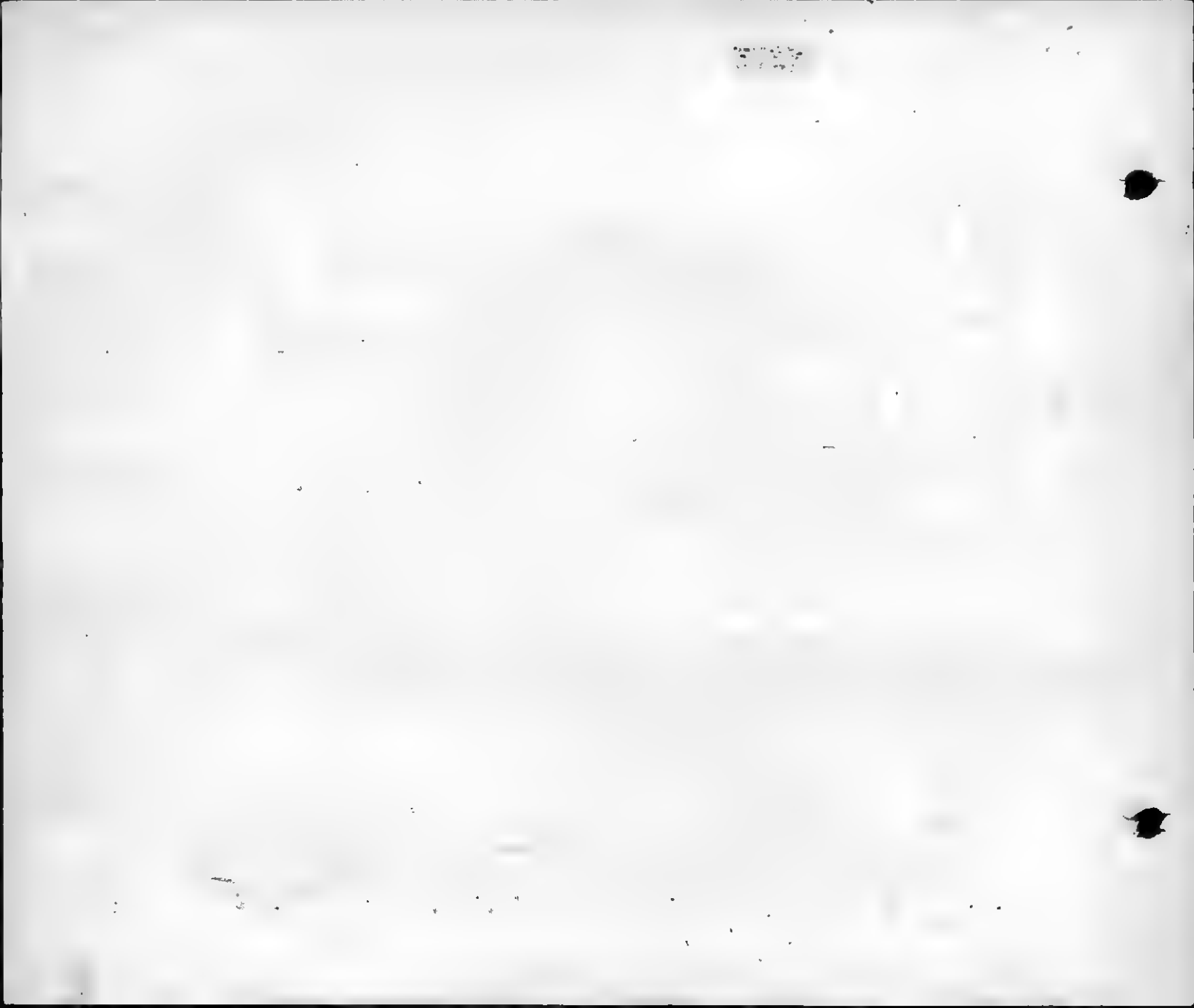
00251

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>7 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 ALBANY AVE.</u>				e. STREET ADDRESS <u>1 517 ALBANY AVE.</u>			
3. NAME OF DECEASED (Type or print) <u>HARRY E. HORAN</u>				4. DATE OF DEATH <u>8-27-59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-70</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY HORAN</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BAYLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Magdalene Plant 1530 N.E. 42nd St. FLA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>301X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension and arteriosclerosis</u> (c) <u>Stroke</u>							INTERVAL BETWEEN ONSET AND DEATH <u>270</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Chin</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 27, 1958</u> to <u>Aug 27, 1959</u> that I last saw the deceased alive on <u>Aug 27, 1959</u> and that death occurred at <u>7942 M</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. A. Holman, M.D.</u>				ADDRESS (Street, city or town, state) <u>507 Underwood ST. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>C. H. Wolobron</u>				DATE SIGNED <u>Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Holman</u>				ADDRESS <u>3821-14 Th. M.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 31 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. S. Hanna</u>			



VS AIS (4)  
ISM 9/SB

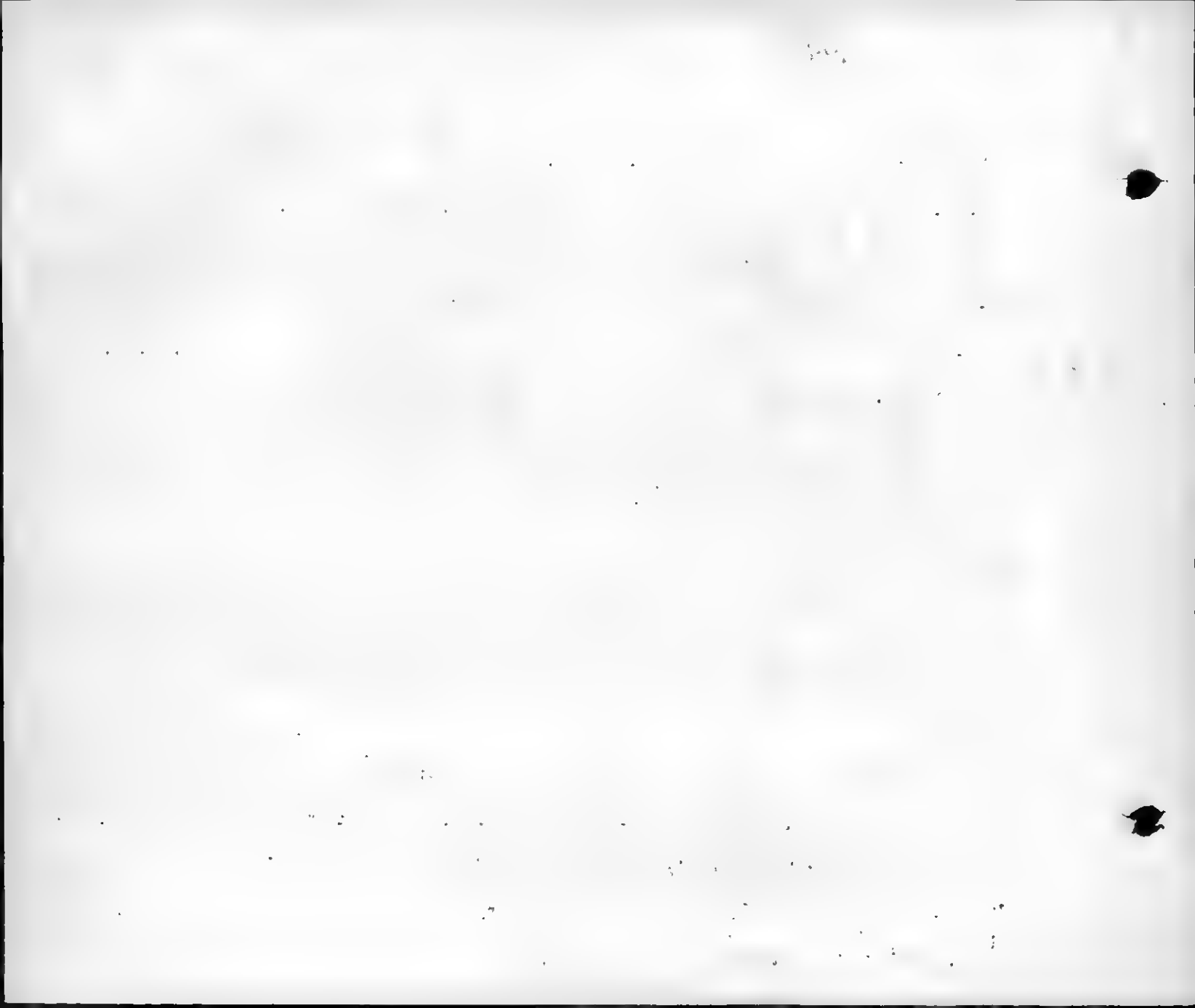
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		<i>4700</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. &amp; Hosp.</i>				d. STREET ADDRESS <i>3022 Wisconsin Ave. NW</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Virginia</i>		Middle <i>CONRAD</i>		Last <i>Hunter</i>		4. DATE OF DEATH Month <i>8</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-2-1911</i>	
9. AGE (In years lost birthday) <i>50 yrs</i>		10. IF UNDER 1 YEAR Months <i>5</i>		11. IF UNDER 24 HRS Days <i>5</i>		12. IF UNDER 24 HRS Hours <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		11. BIRTHPLACE (State or foreign country) <i>W. VA. KENTUCKY</i>	
13. FATHER'S NAME <i>Felix Conrad</i>				14. MOTHER'S MAIDEN NAME <i>Alice M. F.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>1944-1945</i>		17. INFORMANT <i>Christina</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cystosarcoma of prostate gland</i> <i>420.0</i> DUE TO <i>bullet</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>prostate gland congestive failure</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <i>19</i> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1959</i> to <i>1959</i> , that I last saw the deceased alive on <i>1959</i> , and that death occurred at <i>500 Underwood St. NW</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Charles H. Hunter</i> M.D. <i>Charles H. Hunter</i> PHYSICIAN'S NAME (Type) <i>Charles H. Hunter</i>							
22a. BURIAL, CREMATION, OR OTHER (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/31/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>FORT MYER VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William G. Butler's Son</i>				ADDRESS <i>1756 Park Rd. S.E.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 31 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles E. Hunter</i>							





**MEDICAL CERTIFICATION**

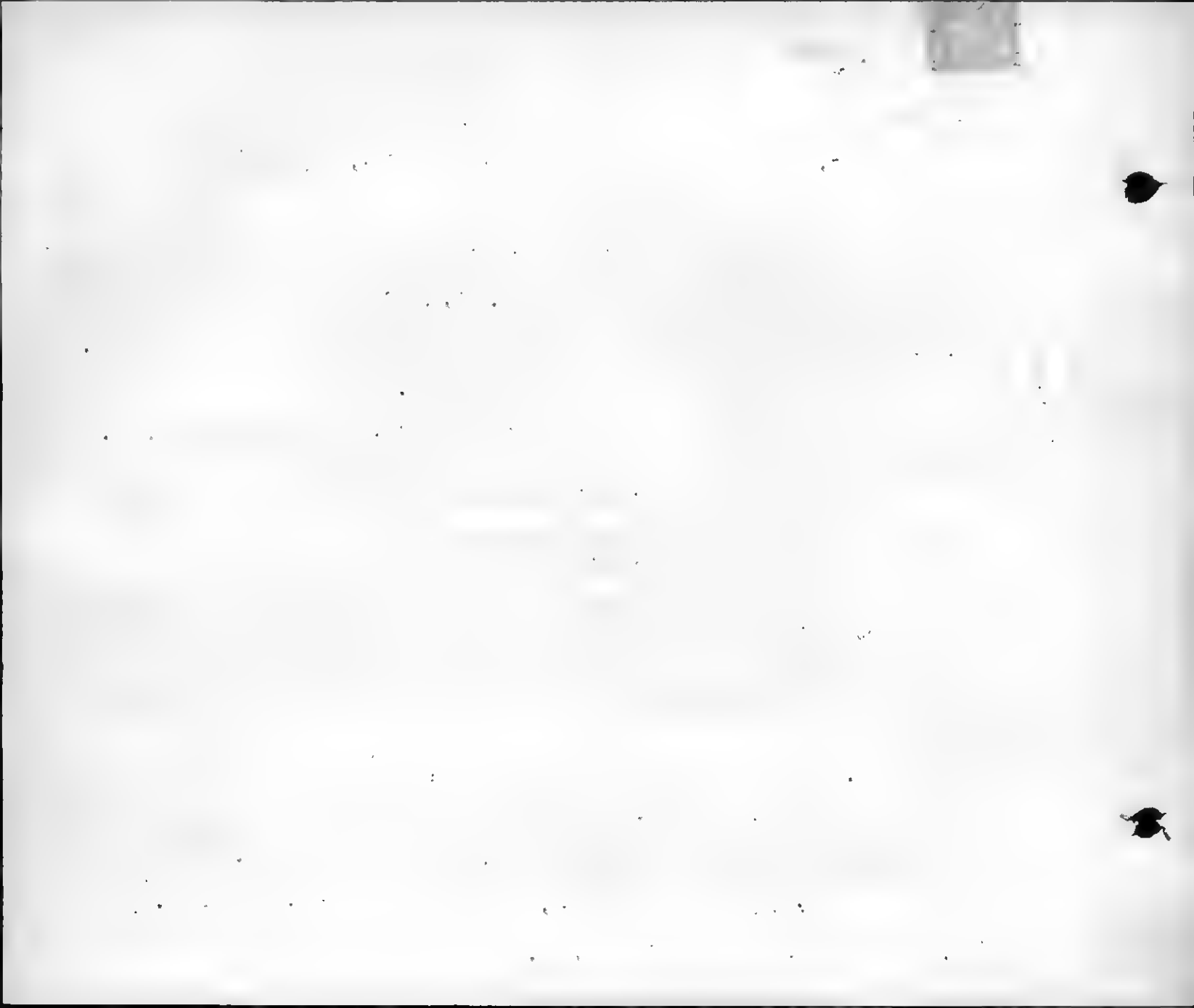
VS AIS (4)  
ISM 9/SB



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09254
9300										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville, (Rural)</u>					c. LENGTH OF STAY IN lb <u>life</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville, (Rural))</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Galeb</u> First <u>James</u> Middle <u>Johnson</u> Last					4. DATE OF DEATH Month <u>Aug</u> Day <u>7</u> Year <u>1999</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1880</u>		9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William Johnson</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth</u> 1					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		INFORMANT <u>Herbert Johnson</u>		Address <u>Spencerville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C R D</u> DUE TO <u>Arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u>									INTERVAL BETWEEN ONSET AND DEATH <u>mh</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 19, 1949</u> to <u>Aug. 7, 1959</u> that I last saw the deceased alive on <u>Aug. 7, 1959</u> and that death occurred at <u>8:07 AM</u> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.					ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>8-9-59</u>					
PHYSICIAN'S NAME (Type) <u>Webster Sewell</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Round Oak,</u>			22d. LOCATION (City, town, or county) (State) <u>Spencerville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorden</u>					ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

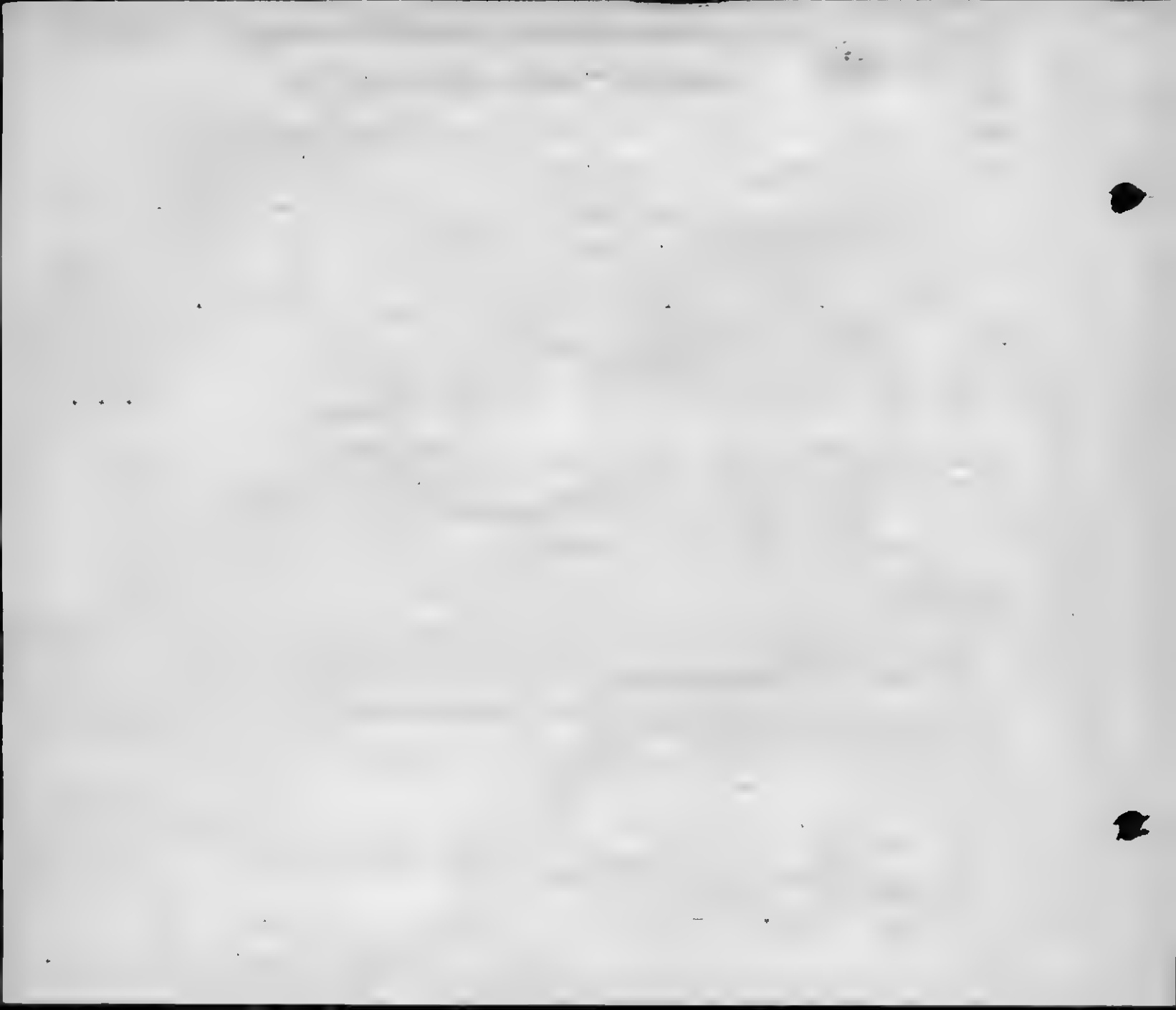
09255

9301

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Montgomery</b>		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Colesville</b>		LENGTH OF STAY (In this place) <b>1 year</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gaithersburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Marilea Nursing Home</b>				STREET ADDRESS (If rural give location) <b>/</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Emily R. Johnson</b>				<b>4. DATE OF DEATH</b> (Month) <b>Aug.</b> (Day) <b>16</b> (Year) <b>19 59</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Sept 27 1887</b>	<b>9. AGE last birthday</b> <b>71</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Lawson Day</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Marilea Nursing Home</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE (A)</b> <b>Cerebral Infarction</b>						<b>4 1/2 hrs</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Cerebral Thrombosis</b>						<b>6 days</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Cerebral Arteriosclerosis</b>						<b>Indefinite</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Hypertension + Congestive Failure</b>						<b>5 yrs</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/1/58, to 8/16/59, that I last saw the deceased alive on 8/15/59, and that death occurred at 1:25 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Stephen D. Jones M.D.</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Rockville, Md.</i> <b>DATE SIGNED</b> <i>8/18/59</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Aug. 19 1959</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mountain Chapel</b>		<b>LOCATION (City, town, or county)</b> <b>Comas Md</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AUG 19 '59</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Arthur S. Frank</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Royce Barber</i> <b>ADDRESS</b> <i>Laytonsville, Md.</i>			



9302

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Henry Johnson</u>				4. DATE OF DEATH Month Day Year <u>8 24 19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18 1932</u>	
9. AGE (In years last birthday) <u>37 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laundryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Joseph Johnson, 112 North St. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of pulmonary artery</u> DUE TO (c) <u>Stab wound.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 1/2 in laceration left arm</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>app. 1 min.</u> <u>app. 2 min.</u> <u>app. 5 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Stab wound in upper left chest</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>9:20</u> p.m. <u>8-24 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Rockville monty md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-25-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Madley's Neck, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Cuthbert H. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director; the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





9303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

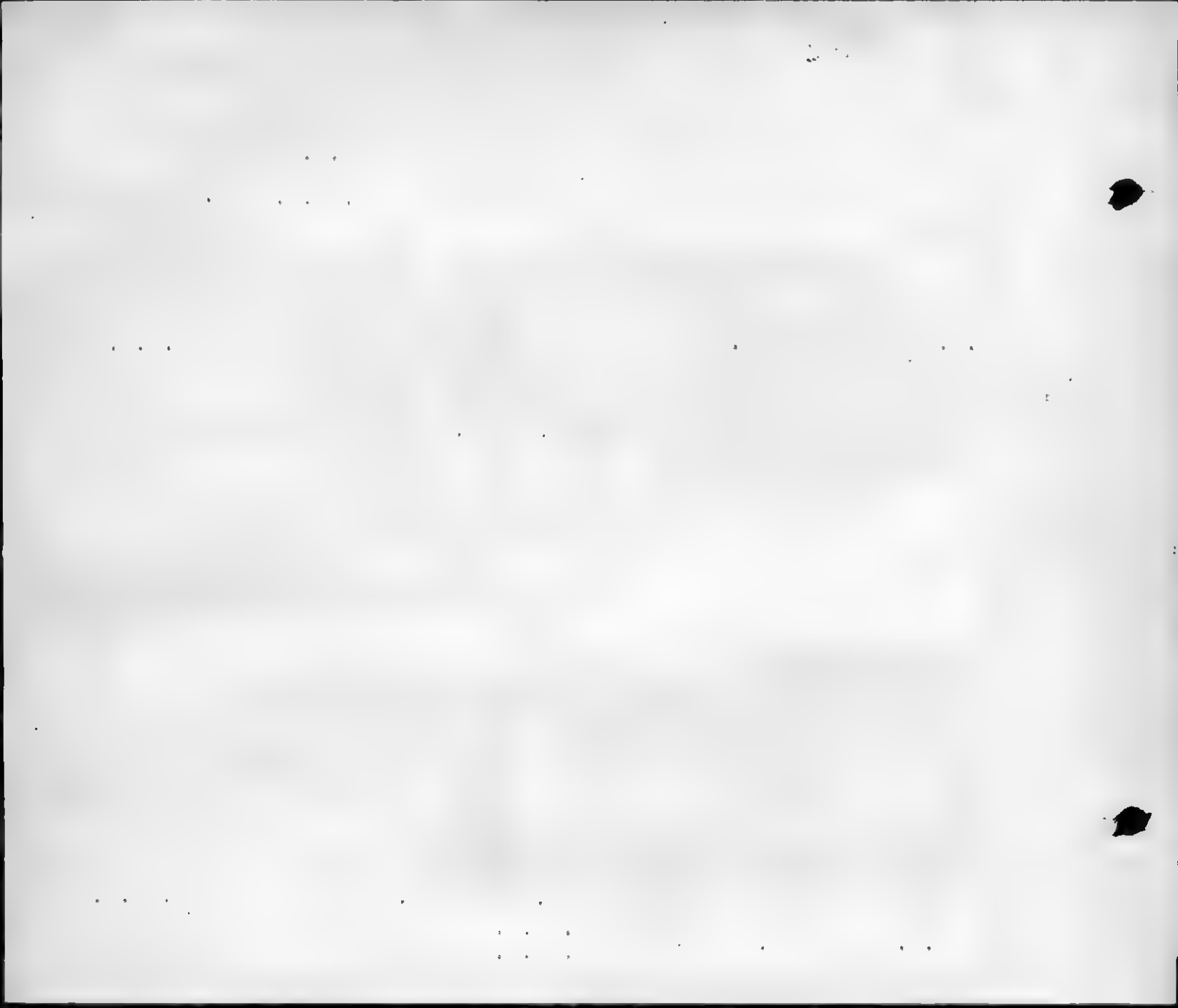
09257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>47x</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sharon Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Thomas Jones</b>		4. DATE OF DEATH Month Day Year <b>August 14, 1959</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/22/70</b>	
9. AGE (in years last birthday) <b>88</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Treasury Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Treasury Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Miller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-24-4488A</b>		17. INFORMANT <b>Pearl A. Jones</b>		Address <b>same as #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4x0.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10+ years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Pleasantville, N.J.</b>		20g. (County) <b>Washington</b>	
21. I certify that I attended the deceased from <b>Aug. 8, 1959</b> , to <b>Aug. 14, 1959</b> , that I last saw the deceased alive on <b>Aug. 11, 1959</b> , and that death occurred at <b>4:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Neene Saw Apt 8/14/59</b> DATE SIGNED ACTUAL SIGNATURE <b>Neil P. Campbell</b> M.D. PHYSICIAN'S NAME (Type) <b>Neil P. Campbell</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Mem. Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pleasantville, N.J.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</b>			
24a. REC'D BY REGISTRAR <b>Aug 25 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Quilley &amp; Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A11 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9304

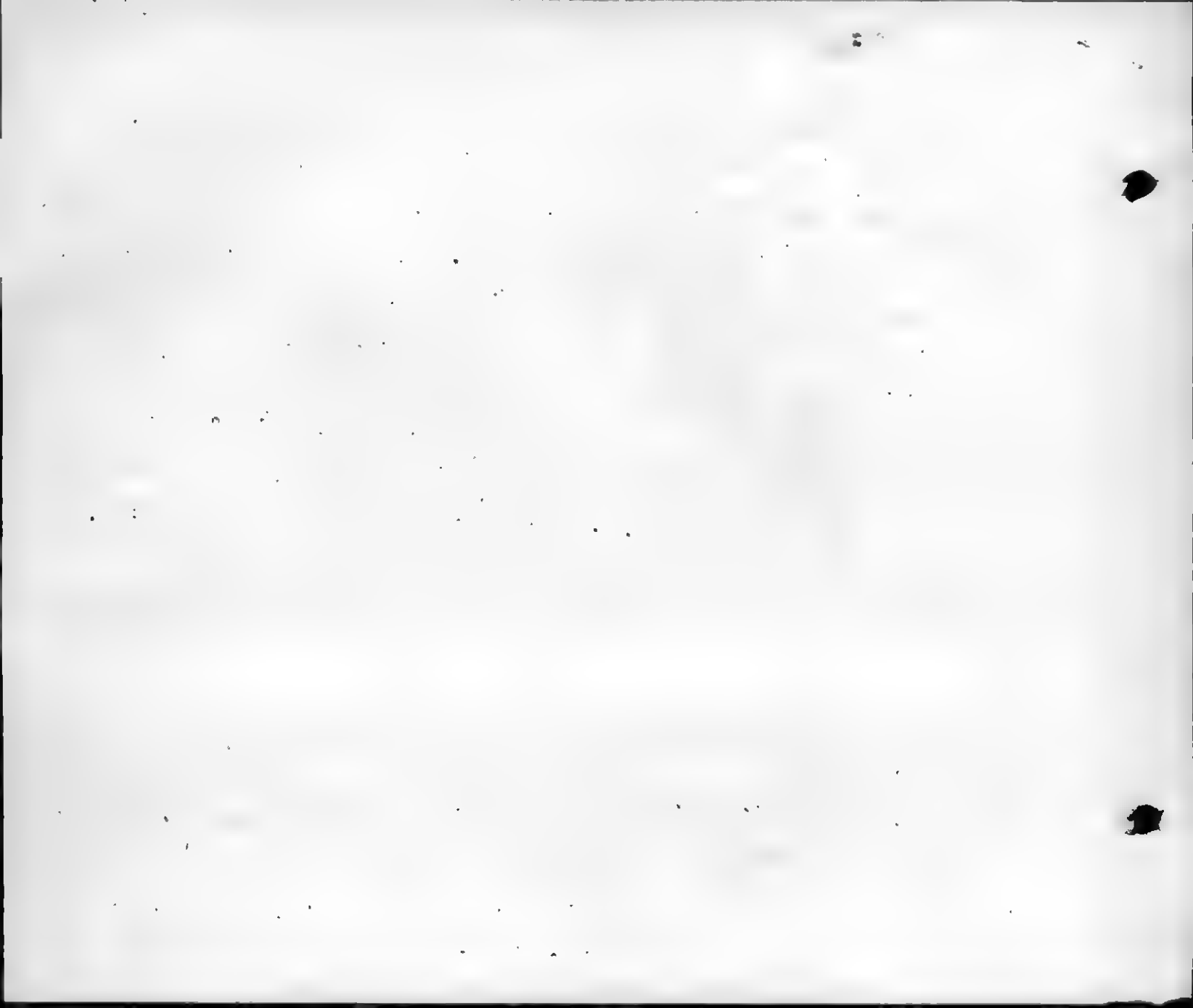
CERTIFICATE OF DEATH

Reg. Dist. No.

119258

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>8216 Nolte Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Lee</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-59</u>
9. AGE (In years last birthday) yrs. <u>19</u> Mo. <u>11</u> Days <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Billy Jules Jones</u>		14. MOTHER'S MAIDEN NAME <u>Hopkins, Vetta Virginia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>aslectasia</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>59</u> , to <u>8/20</u> , 19 <u>59</u> that I last saw the deceased alive on <u>8/20/59</u> and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Auld</u> M.D.		ADDRESS (Street, city or town, state) <u>209 Yew Mill Rd, Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD AULD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Floral Garden Park</u>		22d. LOCATION (City, town, or county) (State) <u>High Point, N. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		24c. REGISTRAR'S NAME <u>—</u>	

2074231X12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9305

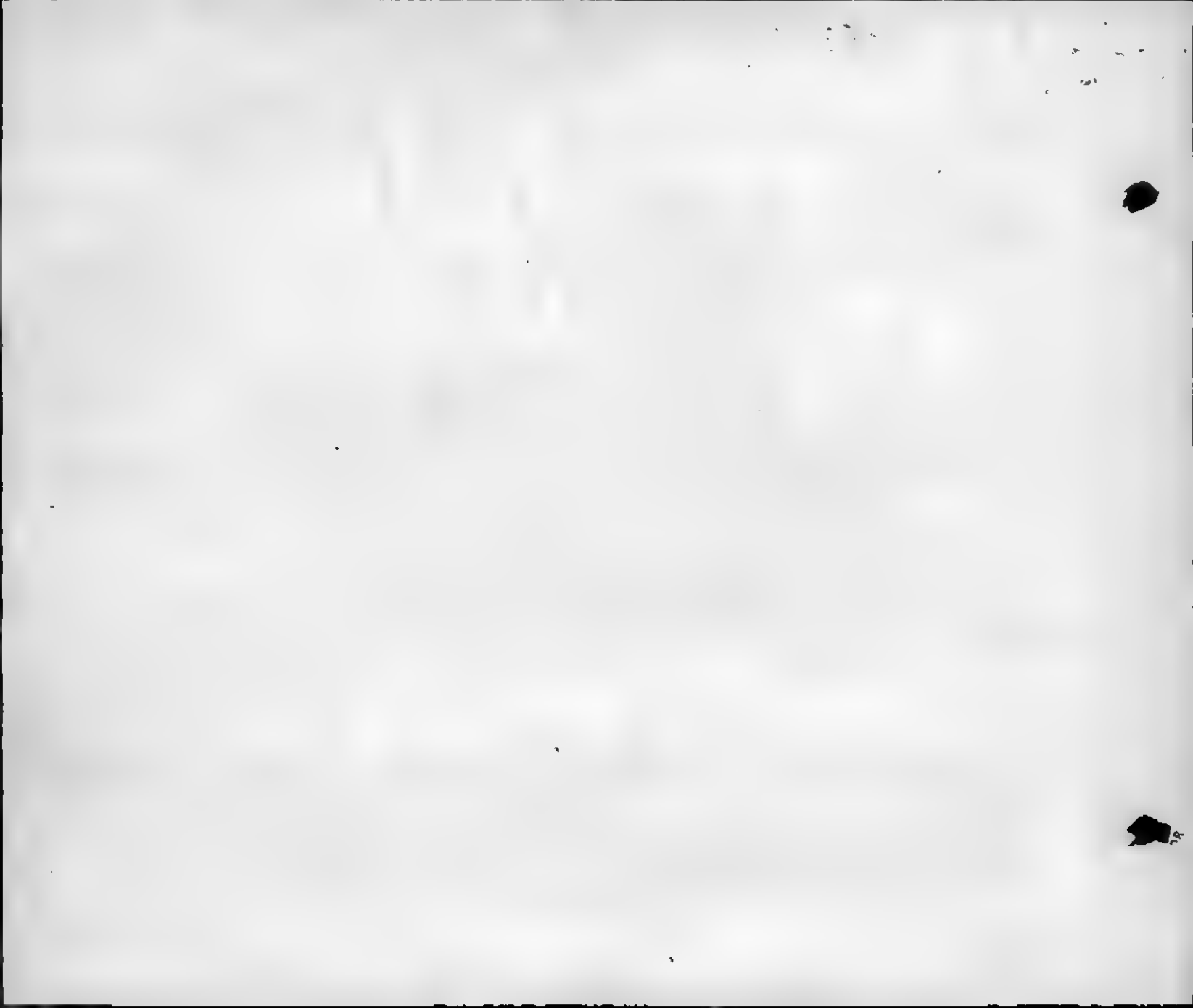
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09259

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) d. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. STREET ADDRESS <u>4711 Warren St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Adeline Kimbell</u>		4. DATE OF DEATH <u>Aug. 30 - 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 - 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Guttenberg, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Schaffer</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Flick BECKETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. or dates of service) <u>-</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Peritonitis</u> DUE TO <u>St. 1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Reptures, Ruptured Aorta</u> DUE TO (c) <u>Peritonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours 8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/30/1959</u> to <u>8/30/1959</u> , that I last saw the deceased alive on <u>8/29/1959</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring, Md. 8/31/59</u>	
ACTUAL SIGNATURE <u>J. M. Bird</u>		M.D. <u>Sandy Spring, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>J. M. BIRD</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SEPT 1, 1959</u>	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>	
22d. LOCATION (City, town, or county) (State) <u>FAIRVIEW, New Jersey</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler Sons, Wash. D. C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

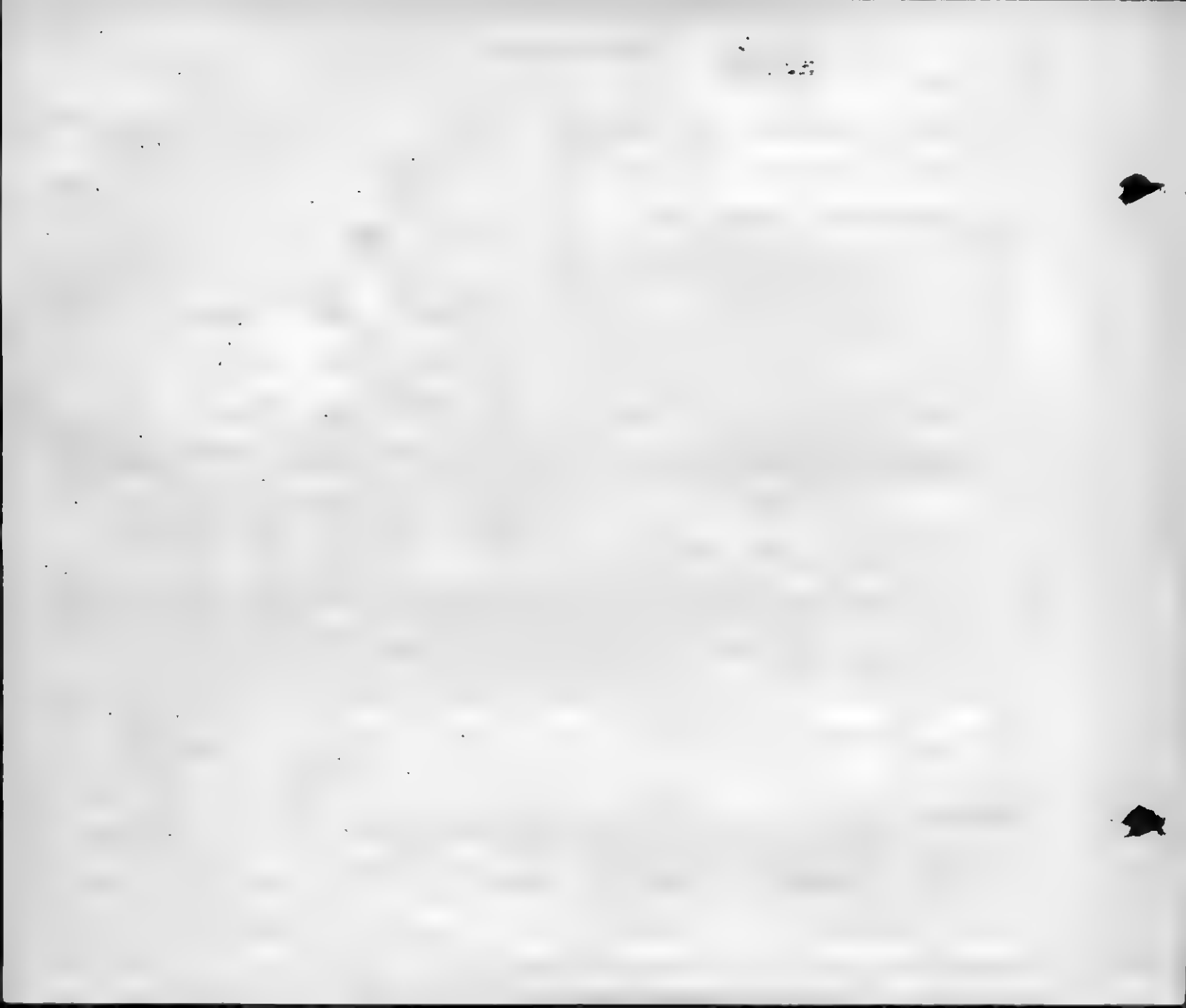


9216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 hrs. 20 min.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan E. Hosp.</u>		e. STREET ADDRESS <u>7503 Flower Ave</u>	
3. NAME OF DECEASED (Type or print) <u>James Noeman Kimble</u>		4. DATE OF DEATH <u>8-13</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-86</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Radiologist</u>		12. KIND OF BUSINESS OR INDUSTRY <u>X-Ray</u>	
13. BIRTHPLACE (State or foreign country) <u>New York</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
15. FATHER'S NAME <u>James D. Kimble</u>		16. MOTHER'S MAIDEN NAME <u>Elizabeth Lane</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>Pl's Hosp. Record</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 2040 DUE TO <u>in long history of leukemia &amp; low platelets</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>The Cause of Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/13/59</u> to <u>8/13/59</u> , that I last saw the deceased alive on <u>8/13/59</u> , and that death occurred at <u>500 Underwood</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. H. Violation</u>		DATE SIGNED <u>8/13/59</u>	
PHYSICIAN'S NAME (Type) <u>Chas. H. Violation</u>		ADDRESS (Street, city or town, state) <u>500 Underwood</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug. 17, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Madison Mills Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ches</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		24. REC'D BY REGISTRAR <u>Aug 17 '59</u>	
ADDRESS <u>254 Canal St NW DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9306

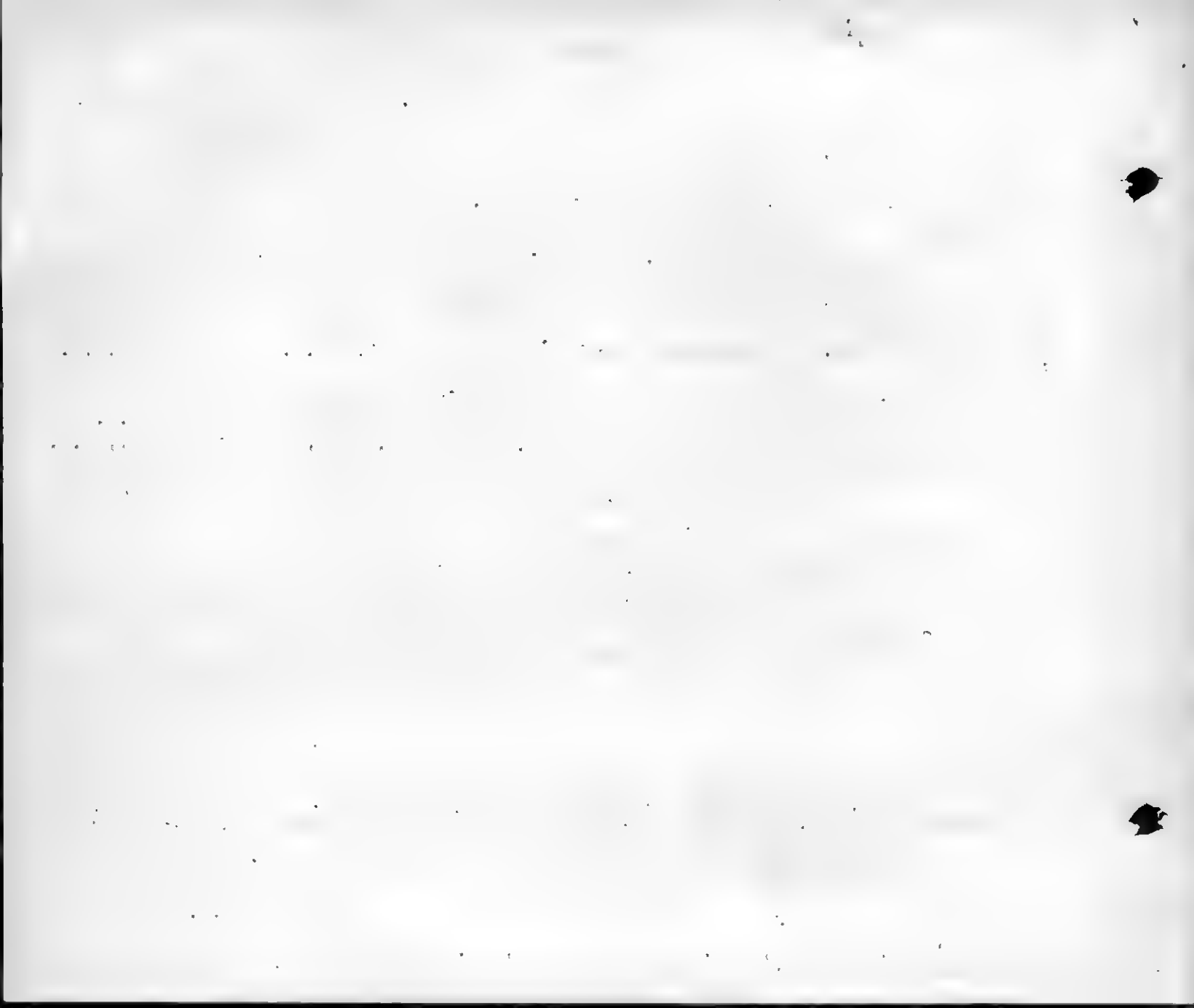
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ALTHEA WOODLAND NURSING HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
f. STREET ADDRESS <b>805 BRANTFORD AVENUE</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>B.</b> Last <b>KING</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/1/67</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>10</b> Min		11. IF UNDER 24 HRS Hours <b>10</b> Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PART OWNER (retired) Equitable Purchasing Co.</b>				11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>			
13. FATHER'S NAME <b>WILLIAM B. BRITTAIN</b>				14. MOTHER'S MAIDEN NAME <b>unknown PAYNE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Mrs. Gertrude E. King, 2800 Quebec St., N.W.</b>				18. WASHINGTON, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Uremia</b> DUE TO (c) <b>Nephrosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 weeks</b> <b>10 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August, 1953</b> to <b>Aug 16, 1959</b> that I last saw the deceased alive on <b>Aug 16, 1959</b> and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph F. Patten</b> M.D.				ADDRESS (Street, city or town, state) <b>8641- Colesville Road Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>RALPH F. PATTEN</b>				DATE SIGNED <b>Aug 16, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>8/19/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>			
ADDRESS <b>SILVER SPRING, MD.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>			



9307

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John HUNTER</u> <u>KRISKO</u>				4. DATE OF DEATH Month Day Year <u>Aug</u> <u>17</u> <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/23/06</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Rice Bakery</u>		9. AGE (In years last birthday) <u>52</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
11. FATHER'S NAME <u>John Krisko</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Army</u>			
15. SOCIAL SECURITY NO. <u>577-1839-73</u>				16. INFORMANT <u>John Krisko, Jr. - Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4.10.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blaschaw</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-17-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Blaschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>Aug 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



09263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>41 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Spartanburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>R. R. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elta</b>		Middle <b>Lois</b>		Last <b>Lancaster</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1899</b>	
9. AGE (In years last birthday) <b>60 yrs</b>		10. IF UNDER 1 YEAR Months <b>60</b>		11. IF UNDER 24 HRS Days <b>60</b>		12. IF UNDER 24 HRS Hours <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis M.-Howard</b>				14. MOTHER'S MAIDEN NAME <b>Lou Sudduth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>197-03-0224</b>		17. INFORMATION <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock secondary to generalized toxemia</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pelvic abscess</b> DUE TO <b>postoperative status - pelvic</b> (c) <b>enteritis for Carcinoma Cecum</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-4 wks</b> <b>4 wks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15</b> , 19 <b>59</b> , to <b>August 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 25</b> , 19 <b>59</b> , and that death occurred at <b>6:45</b> P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b> DATE SIGNED <b>8-26-59</b>							
ACTUAL SIGNATURE <b>Edward D. McLaughlin</b>		M. D. <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Edward D. McLaughlin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>8/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Landrum Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, S. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Calvin S. Kneass</b>			



9309

CERTIFICATE OF DEATH

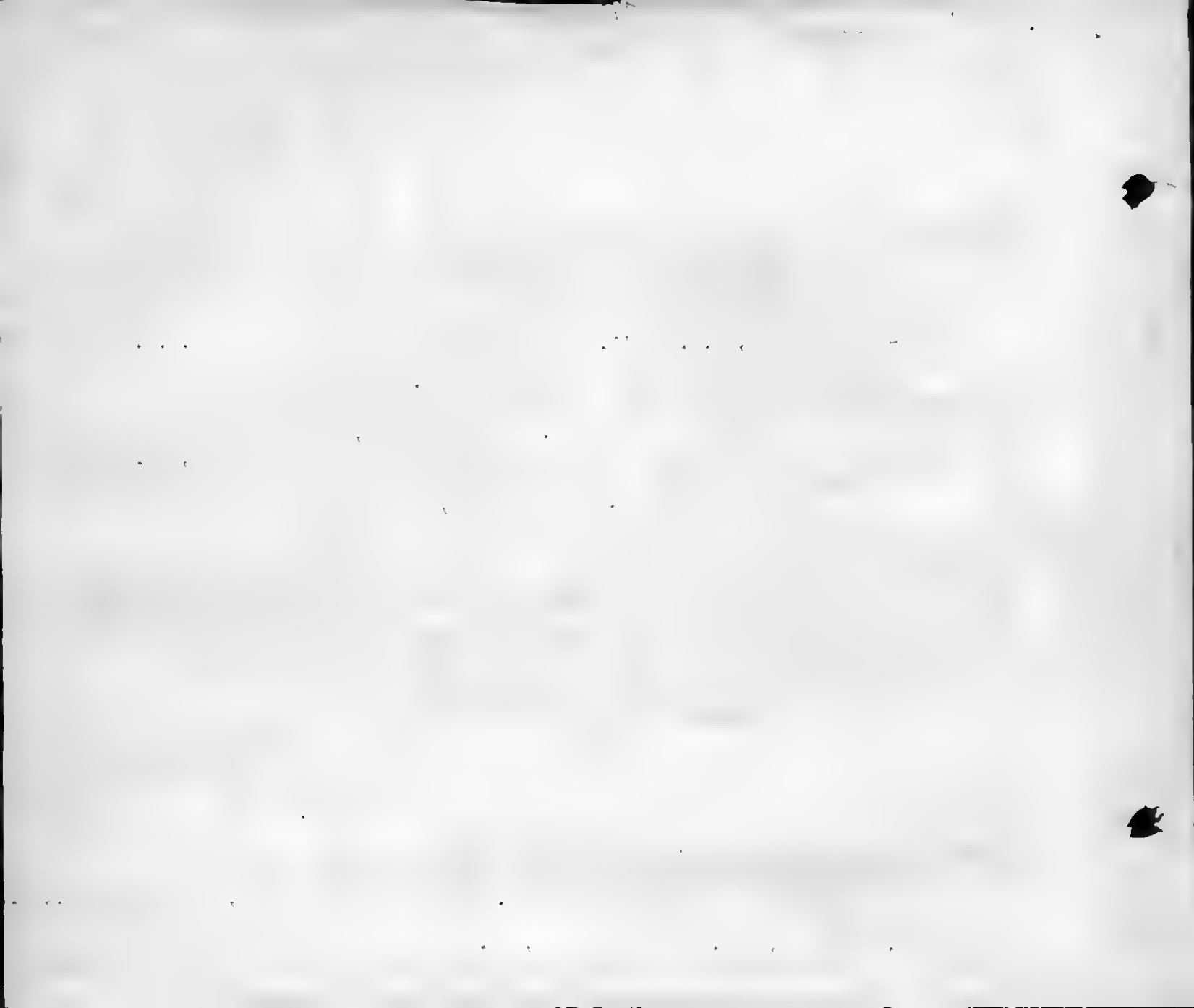
Reg. Dist. No.

10264

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
c. LENGTH OF STAY IN TB <b>22 yrs</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8918 COLESVILLE ROAD</b>				d. STREET ADDRESS <b>8918 COLESVILLE ROAD</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edith Estelle Landers</b>				4. DATE OF DEATH <b>Aug 9 1959</b>			
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/11/77</b>		9. AGE (In years last birthday) <b>82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK - Post Office, U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STILAS WRIGHT DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>ACHSAH L. GROOMES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Eugene Landers, 8918 Colesville Road Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>434.4 DUE TO Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>18 mo. INTERVAL BETWEEN ONSET AND DEATH</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 1958</b> to <b>Aug 9 1959</b> , that I last saw the deceased alive on <b>Aug 7 1959</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John N. Andrews</b>				ADDRESS (Street, city or town, state) <b>9601 Colesville Rd Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>				DATE SIGNED <b>8/9/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville Meth. Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Laytonsville, Montgomery Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	
				24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9310

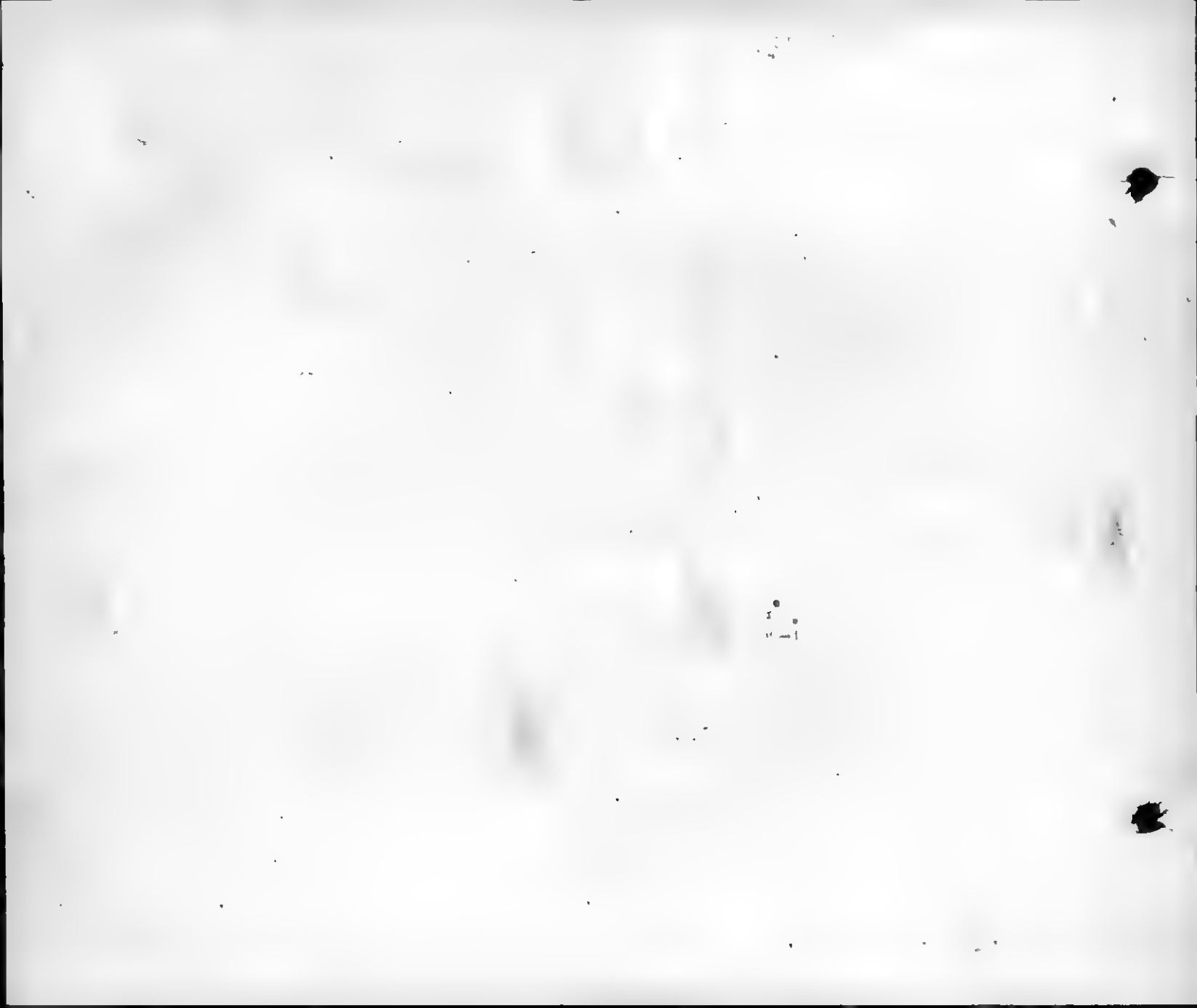
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09265

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
c. LENGTH OF STAY IN 1b <i>9yrs 10mo +</i>				d. STREET ADDRESS <i>4407 Ryewood Wa.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rutherford</i> Middle <i>Barrett</i> Last <i>Lank</i>				4. DATE OF DEATH Month <i>8</i> Day <i>20</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 13, 1919</i>		9. AGE (In years last birthday) <i>40</i> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business Executive</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Woodworking</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				13. FATHER'S NAME <i>William Jefferis Lank</i>			
14. MOTHER'S MAIDEN NAME <i>Elizabeth Stanton</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>NONE</i>				INFORMANT <i>Samuel Th. Lank</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Degeneration</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 wk +</i> <i>6 mo +</i> <i>14 yr +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis</i> <i>12 yr -</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>19-19</i> , 19 <i>59</i> , to <i>8-20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8-19</i> , 19 <i>59</i> , and that death occurred at <i>11:55 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wyrth Post Baker</i> M.D.				ADDRESS (Street, city or town, state) <i>1635 HARVARD ST. Washington D.C.</i> DATE SIGNED <i>8-21-59</i>			
PHYSICIAN'S NAME (Type) <i>WYRTH POST BAKER</i>				22. LOCATION (City, town, or county) (State) <i>Naimans Corner, Delaware.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial-transit 8-21-59</i>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>	
22d. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 24 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinard</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Roman papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 ISM 10/57

9311

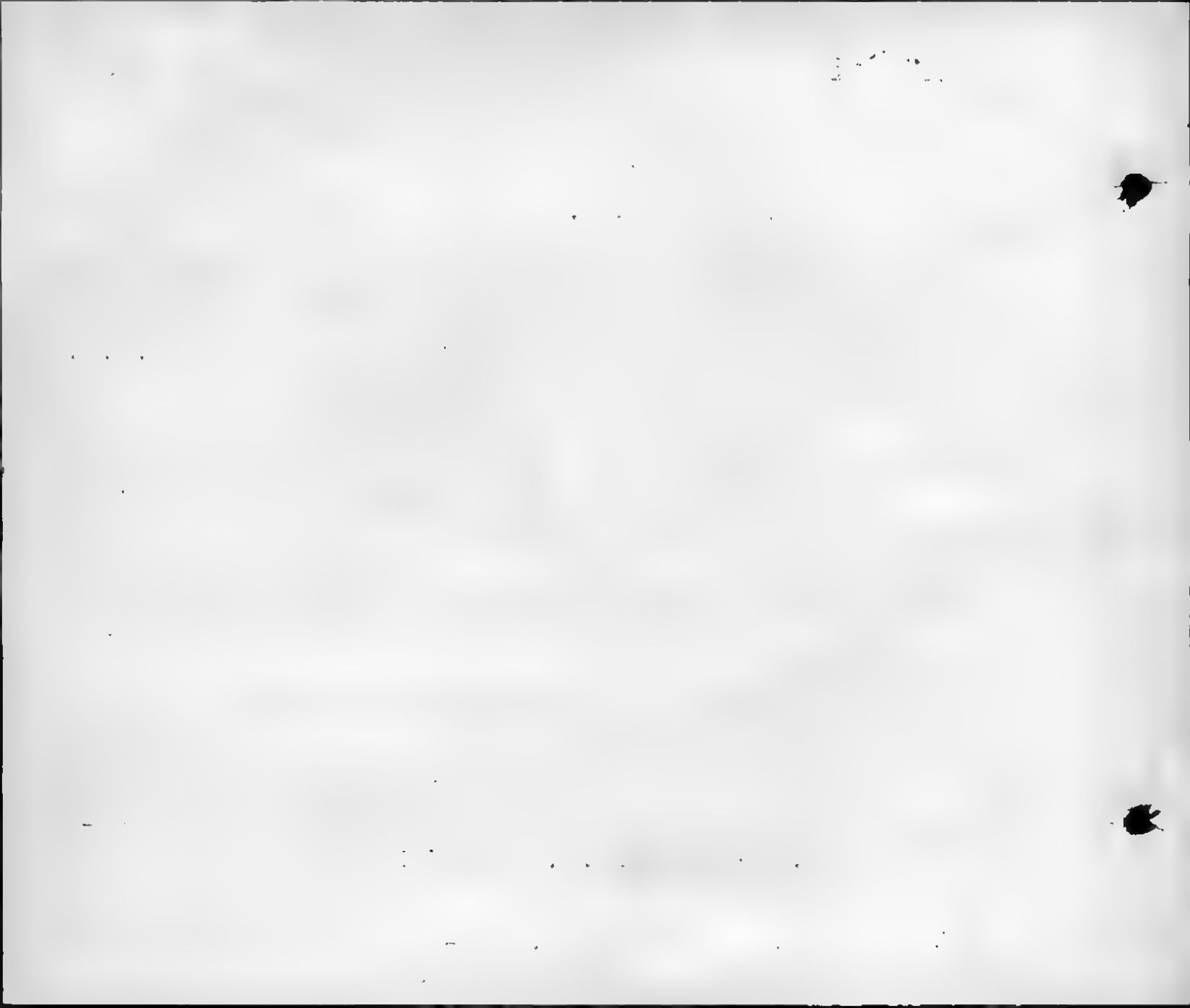
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09266

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>5813 Melbourne Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>Sandra</b> Middle <b>Kay</b> Last <b>Lawson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>January 6, 1954</b>
9 AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Adrian Lawson</b>		14 MOTHER'S MAIDEN NAME <b>Natalie Aylestock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest in postoperative period (surgical correction of Tetralogy of Fallot)</b> DUE TO (b) <b>Tetralogy of Fallot</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 23, 19 59</b> , to <b>August 28, 19 59</b> , that I last saw the deceased alive on <b>August 28, 19 59</b> , and that death occurred at <b>9:40 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. C. Brockenbrough, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edwin C. Brockenbrough, M. D.</b>		DATE SIGNED <b>8-28-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Fairfax Co. Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington Funeral Home</b>		ADDRESS <b>3001 N. Fairfax Drive Arlington 3, Va.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>
		24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

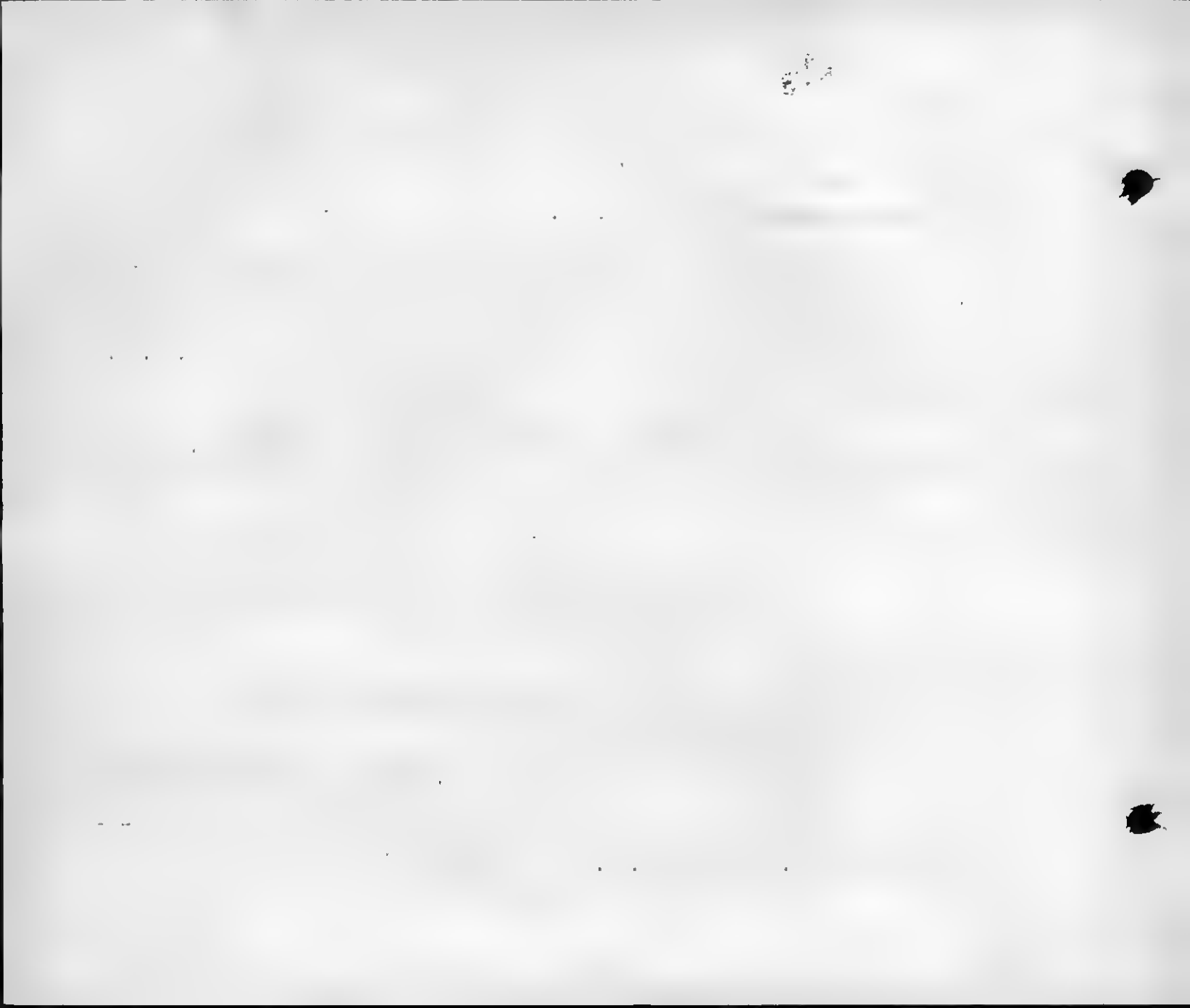
9312

CERTIFICATE OF DEATH

09267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Alabama</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Tom</b> Middle <b>(none)</b> Last <b>Layton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gold Digger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Layton</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Gambell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheal obstruction</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blastomycosis of skin</b> DUE TO (c) <b>Carcinoma of larynx</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>5 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis; Osteoarthritis of spine</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 20</b> , 19 <b>59</b> , to <b>August 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 8</b> , 19 <b>59</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-9-59</b> ACTUAL SIGNATURE <b>Vincent T. Andriole</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Trans Burial</b>		<b>8/11/59</b>		<b>Jefferson Memorial Park</b>		<b>Birmingham Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Calvin S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09268

9313

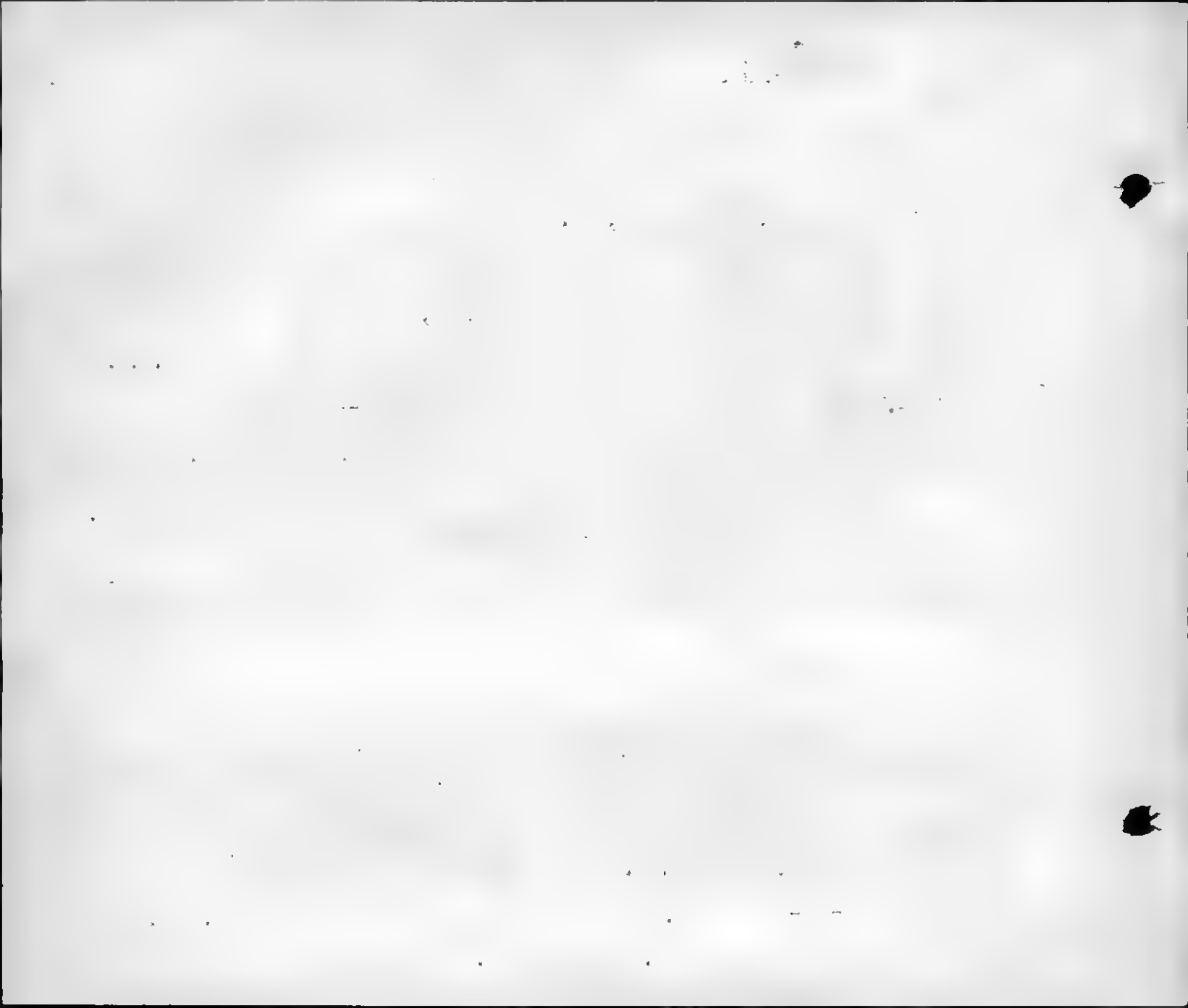
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN It <b>66 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>2904 Cornwall Road</b>			
3. NAME OF DECEASED (Type or print) <b>Susan Ann Leyke</b>				4. DATE OF DEATH <b>August 10 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1953</b>	9. AGE (In years last birthday) <b>6 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin A. Leyke</b>				14. MOTHER'S MAIDEN NAME <b>Rita Muszynski Muszynska</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Upper GI bleeding</b> DUE TO <b>4.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphatic leukemia</b> DUE TO (c) <b>Subdural hematoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>less than 24 hrs. 24 months unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>59</b> , to <b>August 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 10</b> , 19 <b>59</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8/10/59</b>							
ACTUAL SIGNATURE <b>Jerry S. Trier</b> M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M. D.</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kras</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9314

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09269

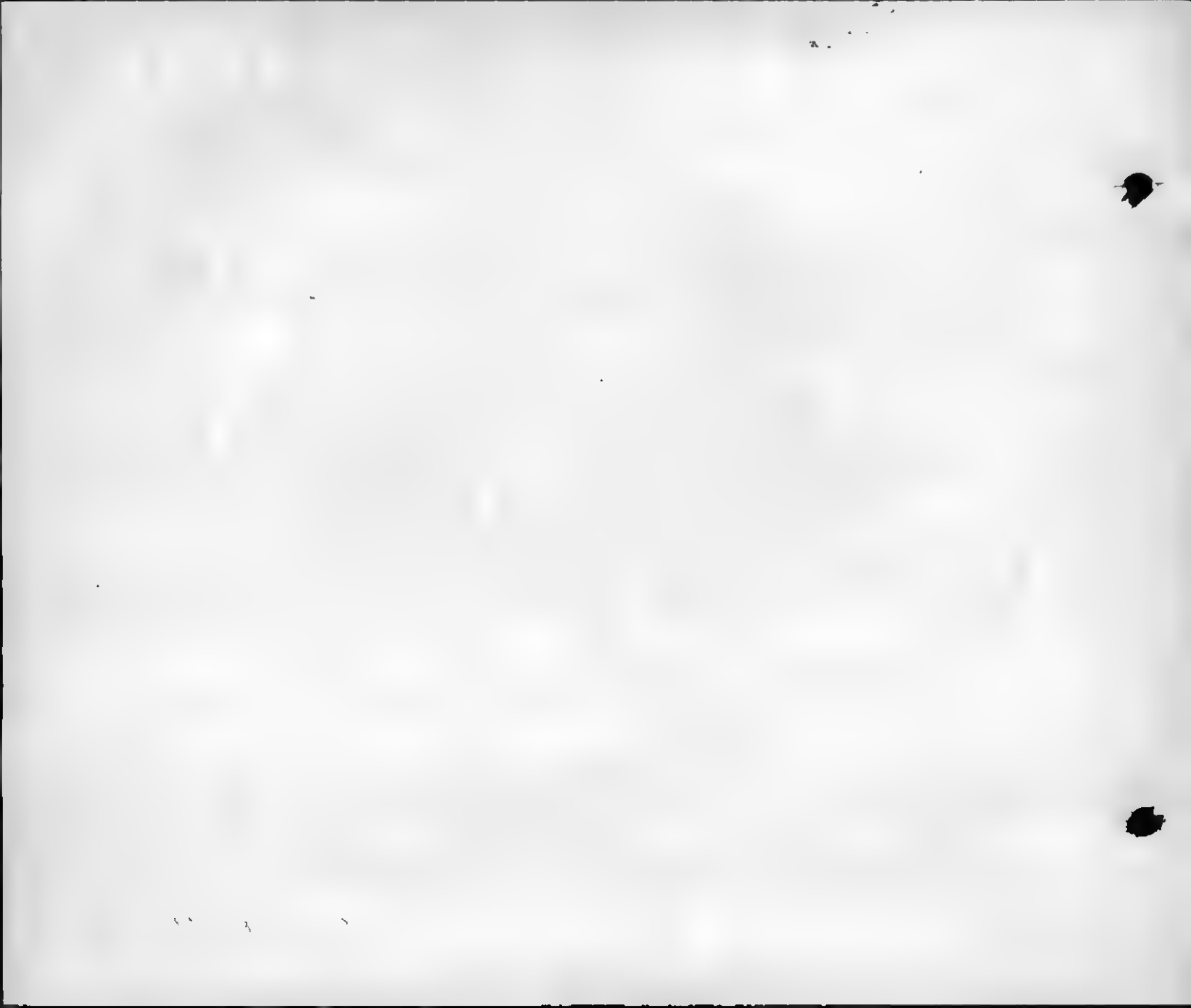
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fatoma Park Spencerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellsworth</u> First Middle Last				4. DATE OF DEATH <u>Aug. 13</u> 19 <u>59</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1861</u>		9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Light</u>				14. MOTHER'S MAIDEN NAME <u>Not Hannah Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6-4-</u> 19 <u>59</u> , to <u>8-13-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8-6-</u> 19 <u>59</u> , and that death occurred at <u>5-25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Sanby Sp...</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>8/13/59</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>254 Carroll St NW SE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



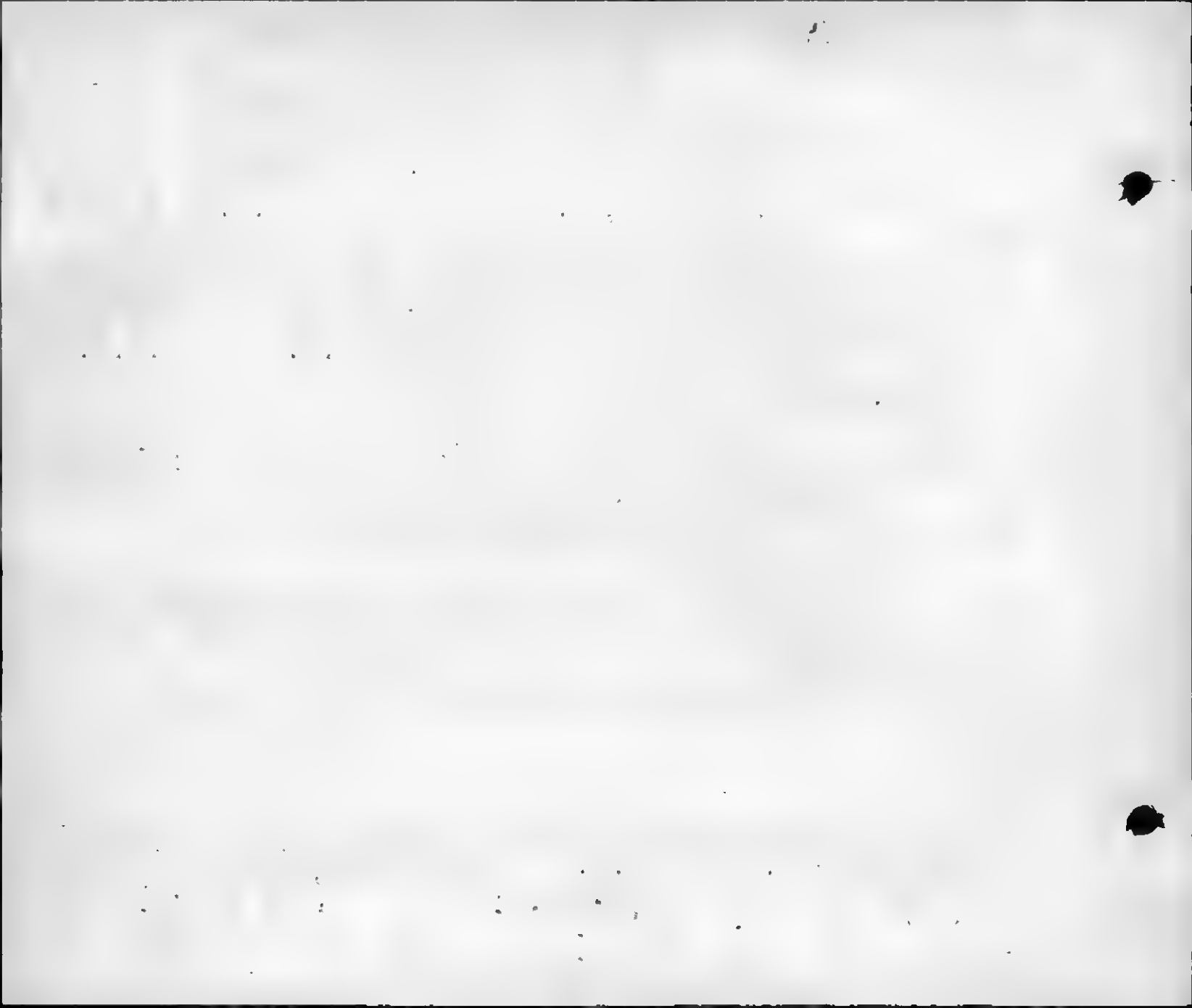
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9315**  
**CERTIFICATE OF DEATH**

09270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>The District of Columbia</b>			
f. STREET ADDRESS <b>101 Kennedy Street, N. E.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Hall Locraft</b>				4. DATE OF DEATH Month Day Year <b>August 31, 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 13, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architect</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>Bernard F. Locraft</b>				14. MOTHER'S MAIDEN NAME <b>Marie DeLacy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, organism unknown</b> <b>200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Reticulum Cell Sarcoma</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 24, 1959</b> to <b>August 31, 1959</b> , that I last saw the deceased alive on <b>August 31, 1959</b> , and that death occurred at <b>6:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-1-59</b>			
PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M. D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Burial Sept. 4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Albans Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Cozelle</b> ADDRESS <b>1722 North Capitol</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



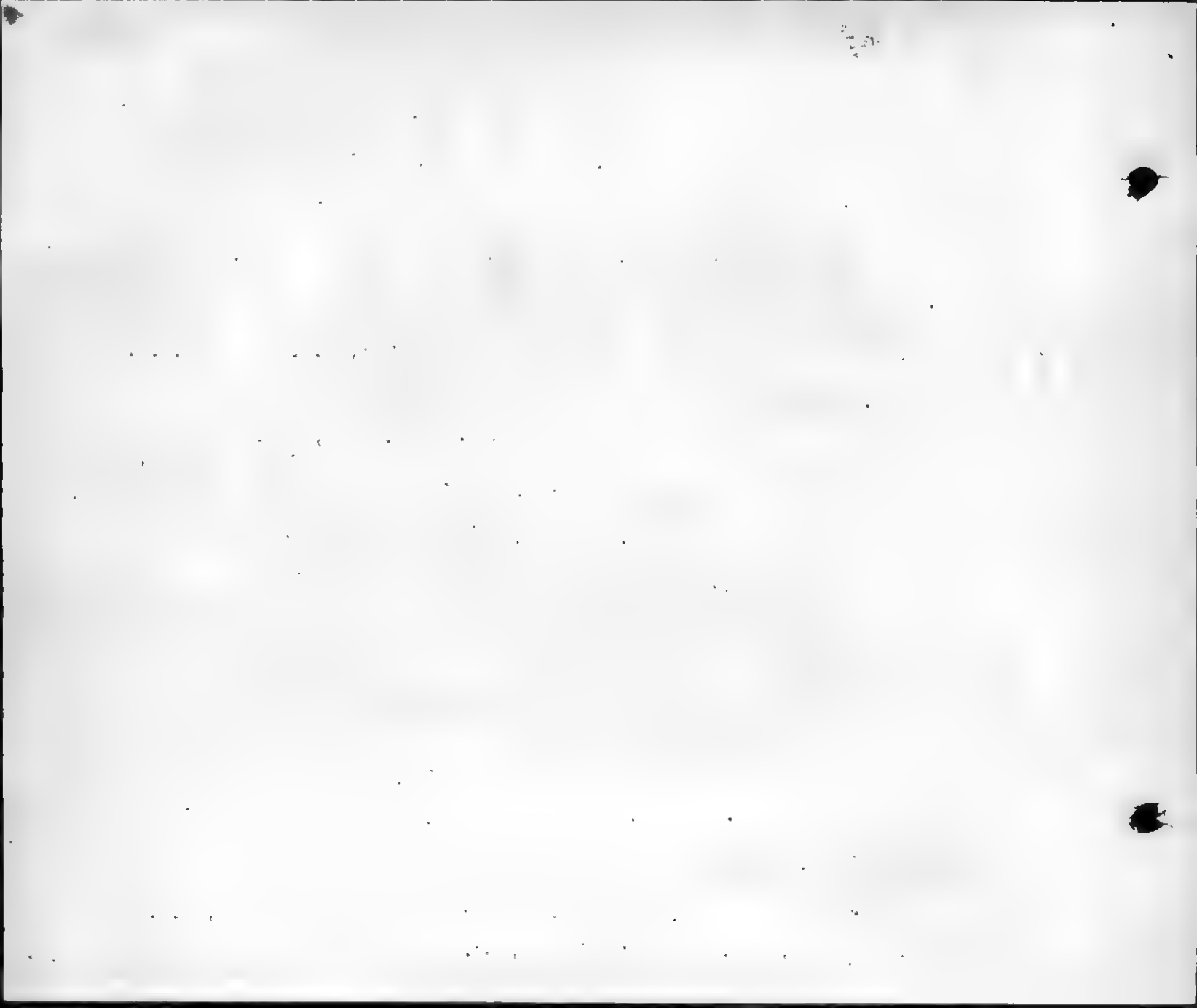
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

09271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>3 Yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1511 FLORA LANE</b>				d. STREET ADDRESS <b>1511 FLORA LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>T.</b> Last <b>LORD</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/7/77</b>	
9. AGE (In years last birthday) <b>82 yrs</b>		10. IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min <b>82</b>		11. IF UNDER 24 HRS Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min <b>82</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM F. TYSER</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH FERRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>none</b>			
17. INFORMANT <b>Miss Margaret T. Lord, 1511 Flora Lane</b>				Address <b>Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>334X</b> DUE TO <b>Hypostatic Pneumonia</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Cerebral Arteriosclerosis</b> DUE TO <b>Generalized Atherosclerosis</b></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>about 3 yrs.</b> <b>?</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June, 1956</b> , to <b>Aug. 24, 1959</b> , that I last saw the deceased alive on <b>Aug. 21, 1959</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter K. Angevine</b>				ADDRESS (Street, city or town, state) <b>6300 - 13th St., N.W., Wash. D.C. 8459</b>			
PHYSICIAN'S NAME (Type) <b>WALTER K. ANGEVINE</b>				DATE SIGNED			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPHREY, INC.</b> <i>Raymond A. Ziskar</i>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



9317

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

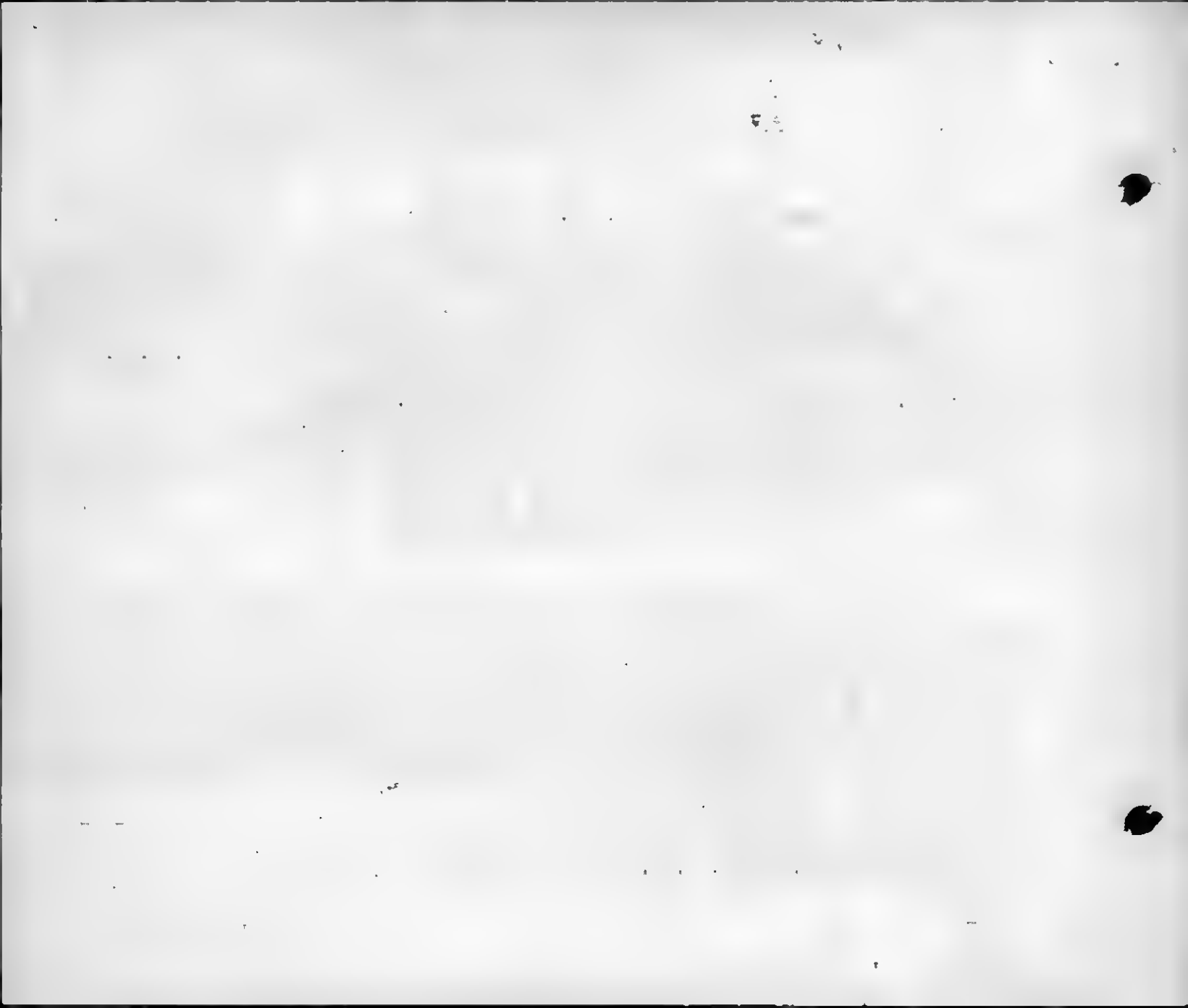
Reg. Dist. No.

09272

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>21st</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>50 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dianne</b> Middle <b>Louise</b> Last <b>Loresch</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1949</b>	
				9. AGE (In years last birthday) <b>10</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
						12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry W. Loresch</b>				14. MOTHER'S MAIDEN NAME <b>Martha C. Peterson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphoblastic Leukemia</b>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 30</b> , 19 <b>59</b> , to <b>August 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 19</b> , 19 <b>59</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center</b> <b>8-20-59</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Jerry S. Trier</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>							
22b. DATE THEREOF <b>8/24/59</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Allegheny Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>Pittsburg, Pennsylvania</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b>							
24a. REC'D BY REGISTRAR DATE <b>AUG 21 '59</b>							
24b. REGISTRAR'S SIGNATURE <b>C. L. S. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9318

## CERTIFICATE OF DEATH

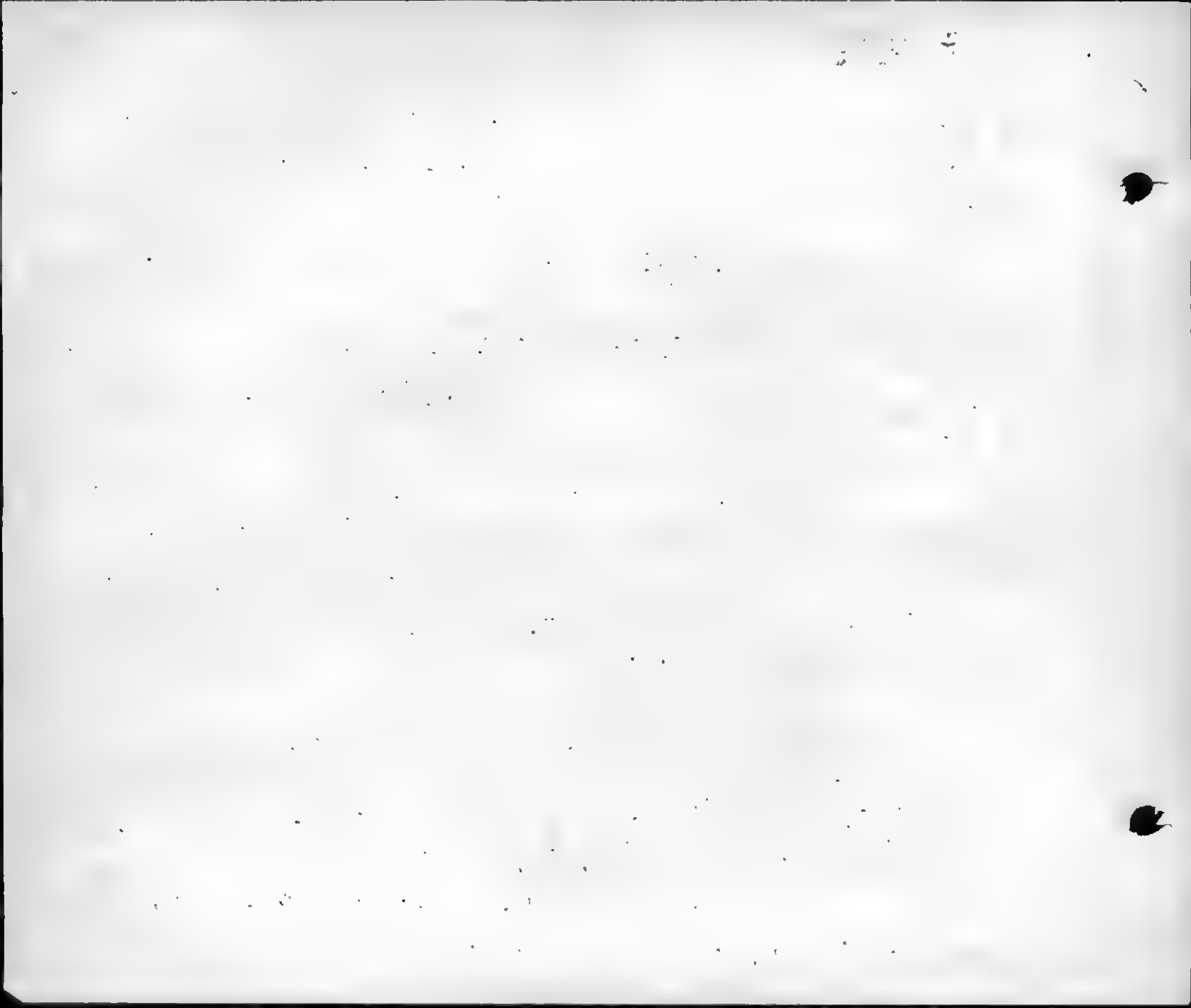
Reg. Dist. No.

09273

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>25 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. STREET ADDRESS <u>550 Belford Place</u>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>Loving</u> Last <u>Loving</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/31/1899</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Diamond Cab. Co.</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Julian H. Loving</u>		14. MOTHER'S MARDEN NAME <u>XXXX XXXXXX VIRGIA GRIMES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>320-124071</u> INFORMANT <u>Rose Loving</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>4700</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) <u>Coronary hyper-tension</u> (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1.1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <u>Essential hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> , 19 to <u>5/30/59</u> , 19, that I last saw the deceased alive on <u>5/30/59</u> , 19, and that death occurred at <u>4:14</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.		ADDRESS (Street, city or town, state) <u>900-17th St. N.W.</u> DATE SIGNED <u>5/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>		<u>Wash &amp; C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneal</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



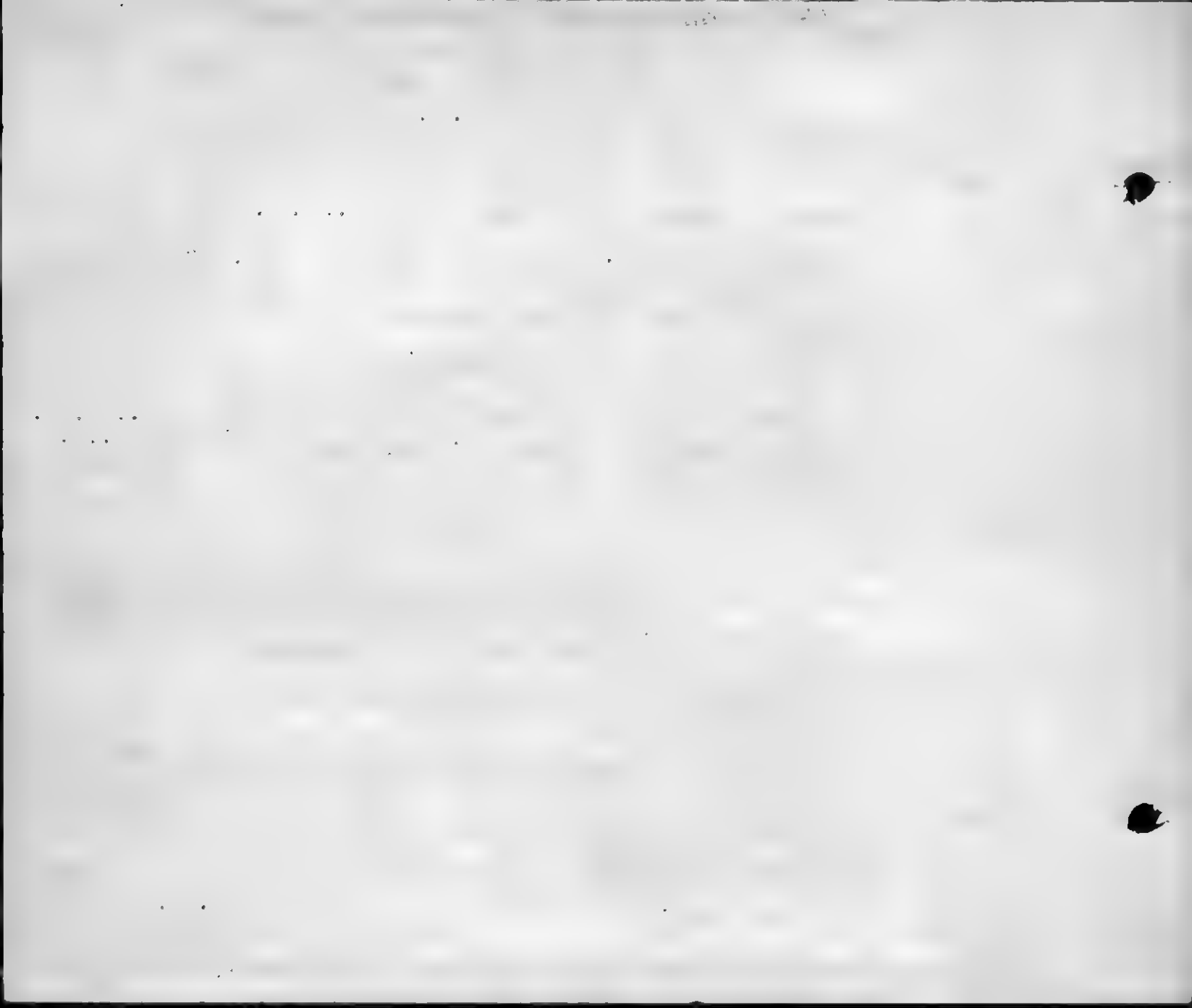
1  
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9319  
CERTIFICATE OF DEATH

09274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3613 Quesada St., N. W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise H. Lytzen</u>		4. DATE OF DEATH Month Day Year <u>Aug. 20 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/87</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>D. William Horgan</u>		14. MOTHER'S MAIDEN NAME <u>MARY SWEENEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WALTER W. LYTZEN, 3613 QUESADA ST., N.W.</u>		Address <u>WASH., D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Necrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholangitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pyelonephritis, Left</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1947</u> to <u>Aug 20, 1959</u> , that I last saw the deceased alive on <u>Aug 20, 1959</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St Wash D.C.</u> DATE SIGNED <u>8/21/59</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons, Wash, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. H. Hines</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9231

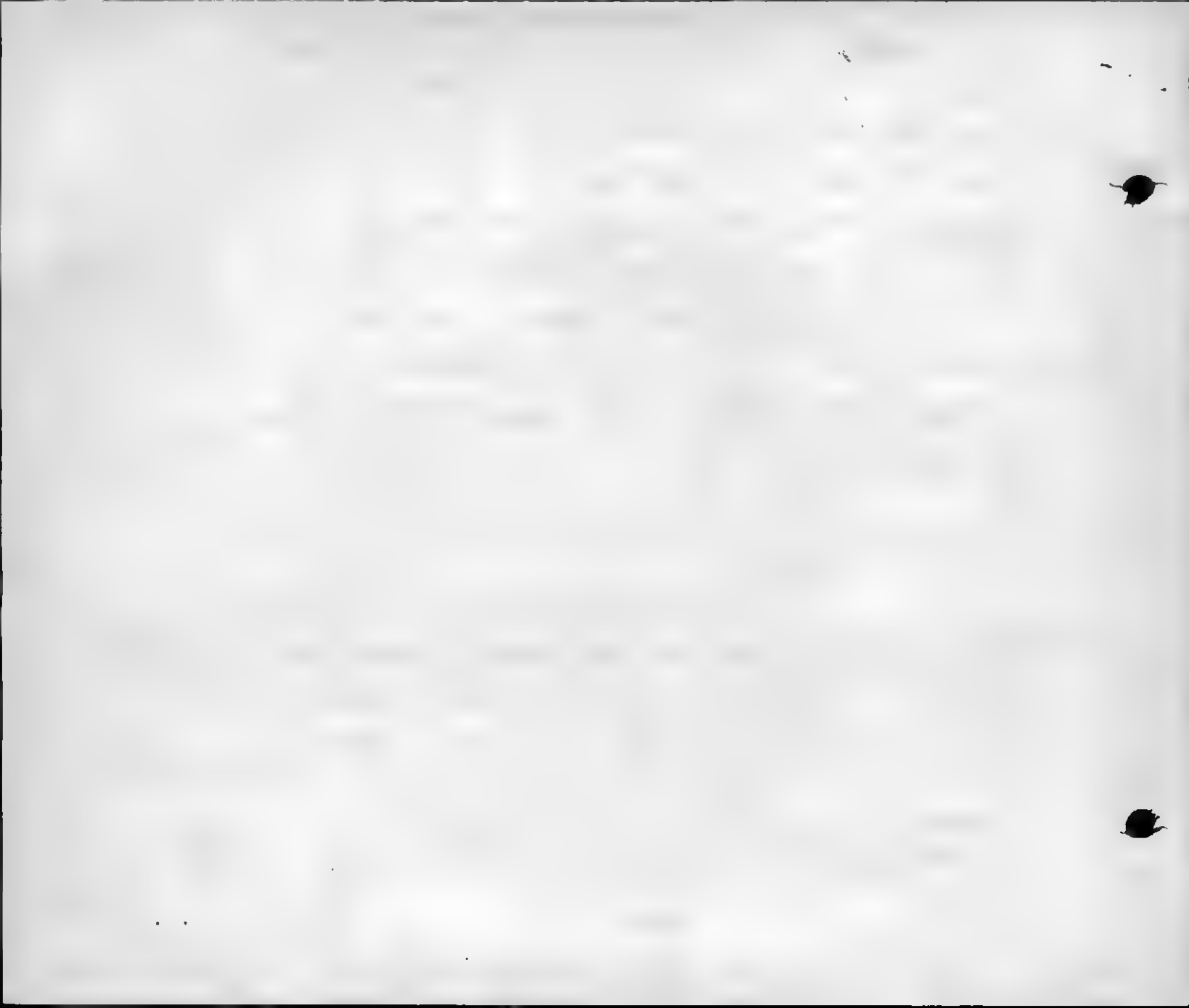
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5733 Crawford Dr</u>				d. STREET ADDRESS <u>5733 Crawford Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Olaf Maddren</u>				4. DATE OF DEATH Month Day Year <u>Aug 27 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1913</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Alfred G Maddren</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-28142</u>		17. INFORMANT <u>Mr Eugene Jackson</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschat</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschat</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-27-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> - <u>1331 E. Montgomery Ave.</u> <u>Rockville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneas</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

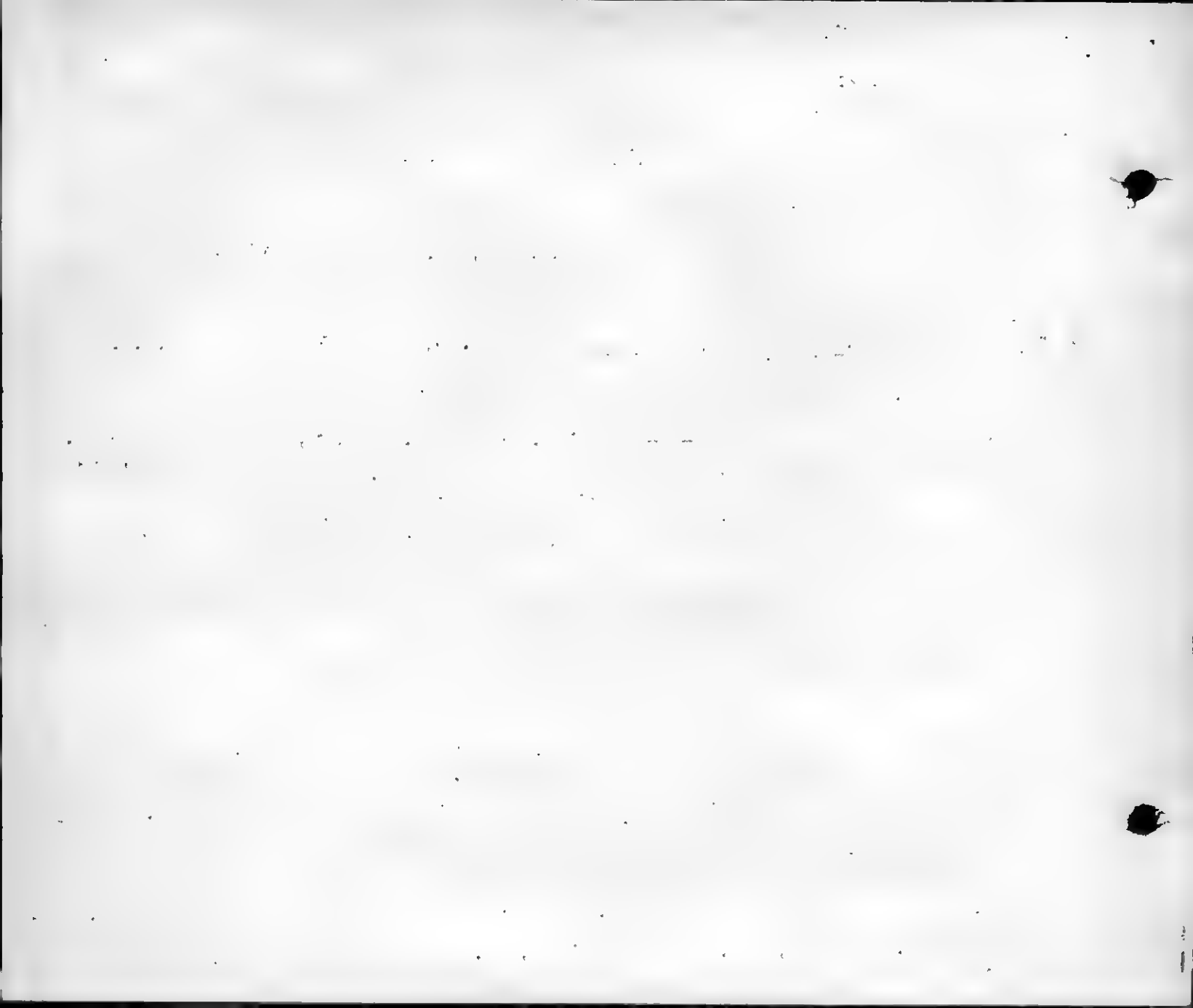
VS A15 (4)  
ISM 9/58

1  
9320  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8720 Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A</b> Last <b>MARLOWE, SR.</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/96</b>
9. AGE (In years lost birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor (self-employed)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>ASHTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS R. MARLOWE</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-03-8193</b>	
17. INFORMANT <b>Mrs. Susanna M. Marlowe, 8720 Colesville Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/19/1956</b> to <b>8/6/1959</b> , that I last saw the deceased alive on <b>7/17/1959</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D. <b>8801 Colesville Road, Silver Spring, Md.</b>		DATE SIGNED <b>8/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D. Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>COLESVILLE, MONTGOMERY CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Fink</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 10 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Clair E. Thomas</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

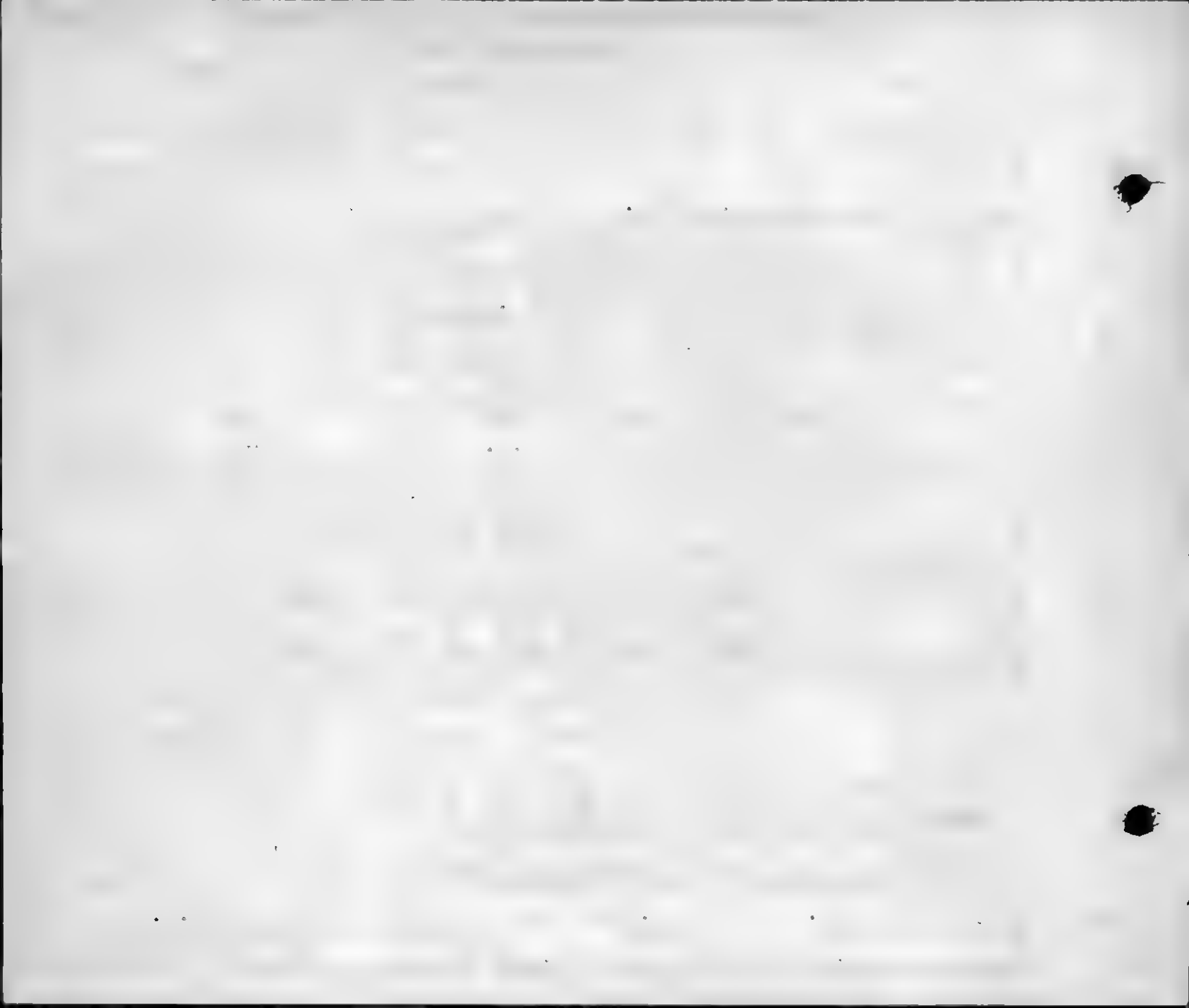
9321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

00277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Point</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5719 Mass. Avenue, NW-ext.</u>		e. STREET ADDRESS <u>5719 Mass. Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernardine</u> Middle <u>Fenwick</u> Last <u>Marsh</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1870</u>
9. AGE (In years last birthday) <u>88 yrs</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Leonardtwn, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Fenwick</u>		14. MOTHER'S MAIDEN NAME <u>Alice Herbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. N. Ward Guthrie--#2d-Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>4:00 P.M.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 7, 1959</u> , to <u>August 18, 1959</u> , that I last saw the deceased alive on <u>August 17, 1959</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>James W. Egan</u>		M.D. <u>7720 Wisconsin Ave., Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James T. Ryan, Inc.</u>		ADDRESS <u>317 Pa. Ave., SE DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. Ryan</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

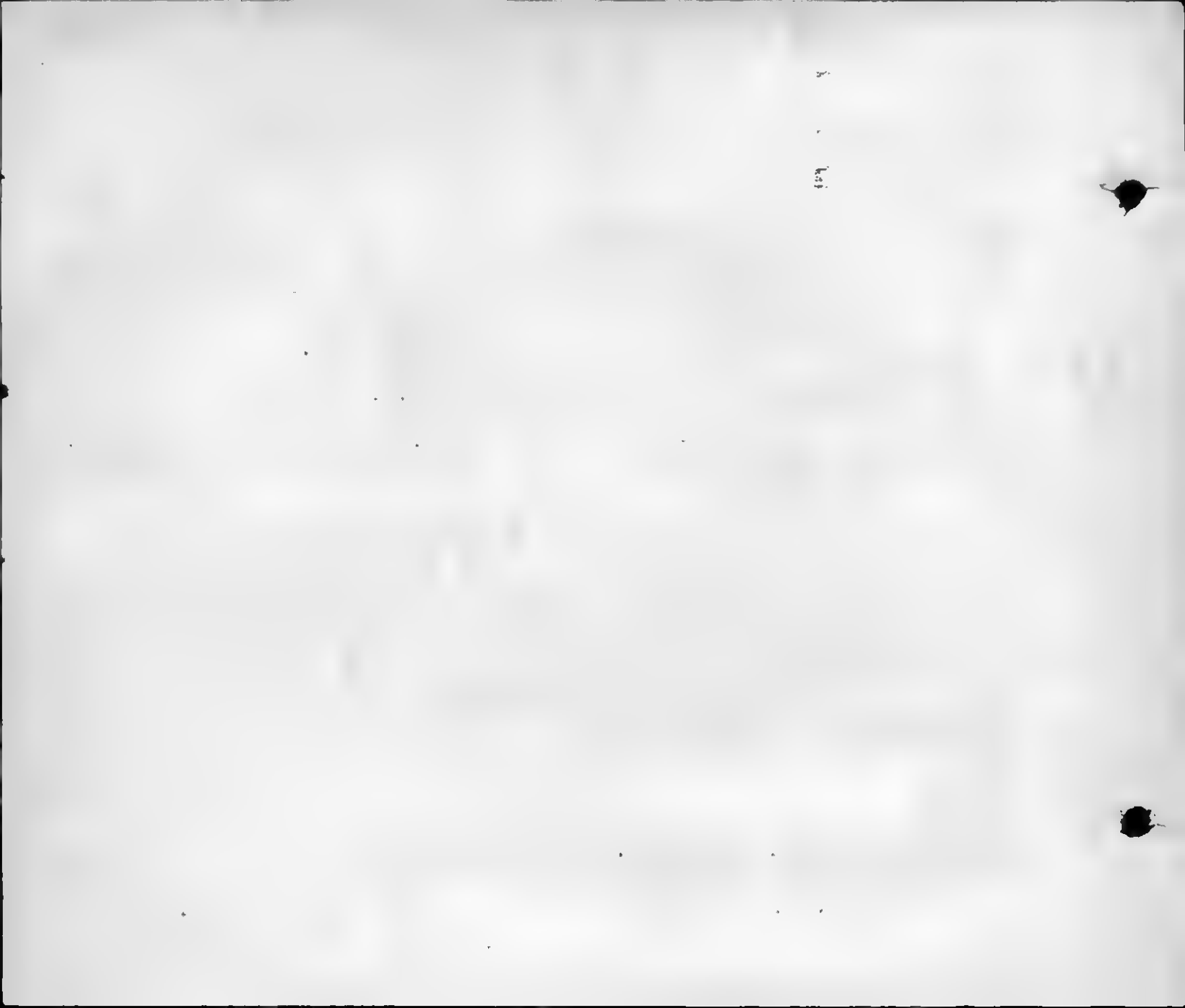
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15M 9/55

9322 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural* Woodfield</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD Gaithersburg</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural- Woodfield</b>			
				f. STREET ADDRESS <b>RFD Gaithersburg</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Idella Burdette Mathers</b>				4. DATE OF DEATH Month Day Year <b>August 2 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 11, 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Woodfield, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Singleton King</b>		14. MOTHER'S MAIDEN NAME <b>Mary R.E. Burdette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>215-32-2430</b>		17. INFORMANT Address <b>Mrs Lucy M. Braun, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Hemorrhage</b> DUE TO (b) <b>Intermittent cardiac conduction disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1946</b> to <b>August 2, 1959</b> , that I last saw the deceased alive on <b>August 2, 1959</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>1200 N. ...</b> DATE SIGNED <b>8/4/59</b>							
ACTUAL SIGNATURE <b>James P. Kerr</b>				M.D. <b>James P. Kerr</b>			
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Woodfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. W. Pleasant</b>				ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 6 '59</b>							



9323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9810 GA. AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>INEZ</u> Middle <u>MAY</u> Last <u>HEW</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1881</u>
9. AGE (In years, day, month, and year) yrs. <u>76</u> Months <u>11</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Ann Taliaferro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2220 Band Pl. Wash. D.C.</u>	
17. INFORMANT <u>Anne E. Beyer</u> Address <u>2220 Band Pl. Wash. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential HTN - RENEWED</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 14, 1954, to Aug. 13, 1957</u> , that I last saw the deceased alive on <u>Aug. 13, 1957</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>5206 103-0127</u> <u>8/13/57</u> PHYSICIAN'S NAME (Type) <u>Chas. H. H. H.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Mt. Wash. D. C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Lee</u> ADDRESS <u>Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hume</u>			



9324

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

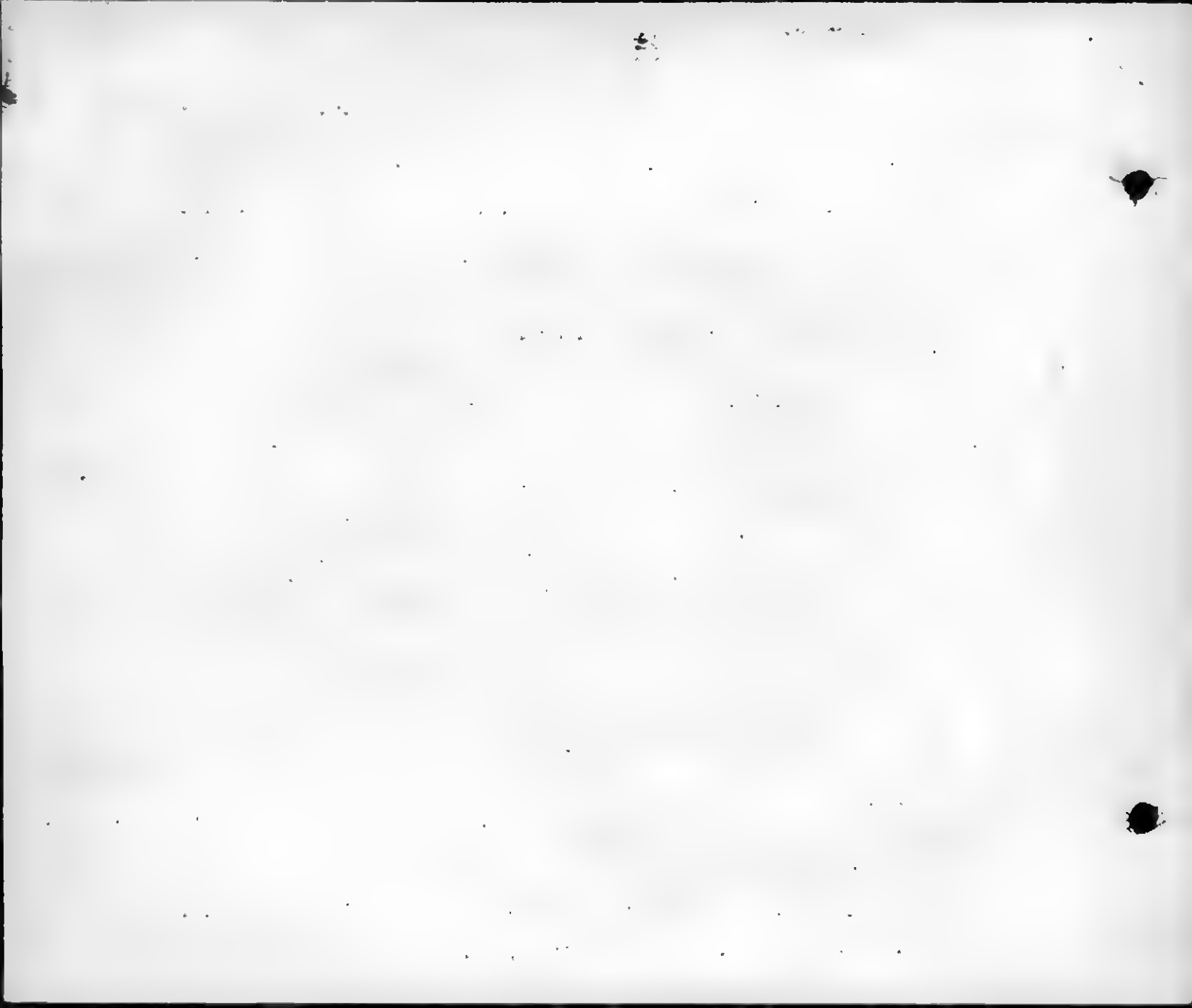
Reg. Dist. No.

19280

1. PLACE OF DEATH a. COUNTY <b>TGO ERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>31 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MAYO JR.</b> Last <b>MAYO JR.</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/77</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Mechanical Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>ROBERT MAYO, SR.</b>	
14. MOTHER'S MAIDEN NAME <b>ANN EL IZA BASS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>WIFE (SAME AS ABOVE)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Eysanguination</b> DUE TO <b>Hemorrhage from Splenic Artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Penetrating Duodenal Ulcer</b> DUE TO <b>Penetrating Duodenal Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 18</b> , 19 <b>59</b> , to <b>Aug. 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 20</b> , 19 <b>59</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>18620 Har. Ave., Silver Spring, Md.</b> DATE SIGNED <b>8/20/59</b> ACTUAL SIGNATURE <b>Philip H. Varner</b> M.D. <b>18620 Har. Ave., Silver Spring, Md.</b> PHYSICIAN'S NAME (Type) <b>PHILIP H. VARNER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Orthur L. Frank</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9325

## CERTIFICATE OF DEATH

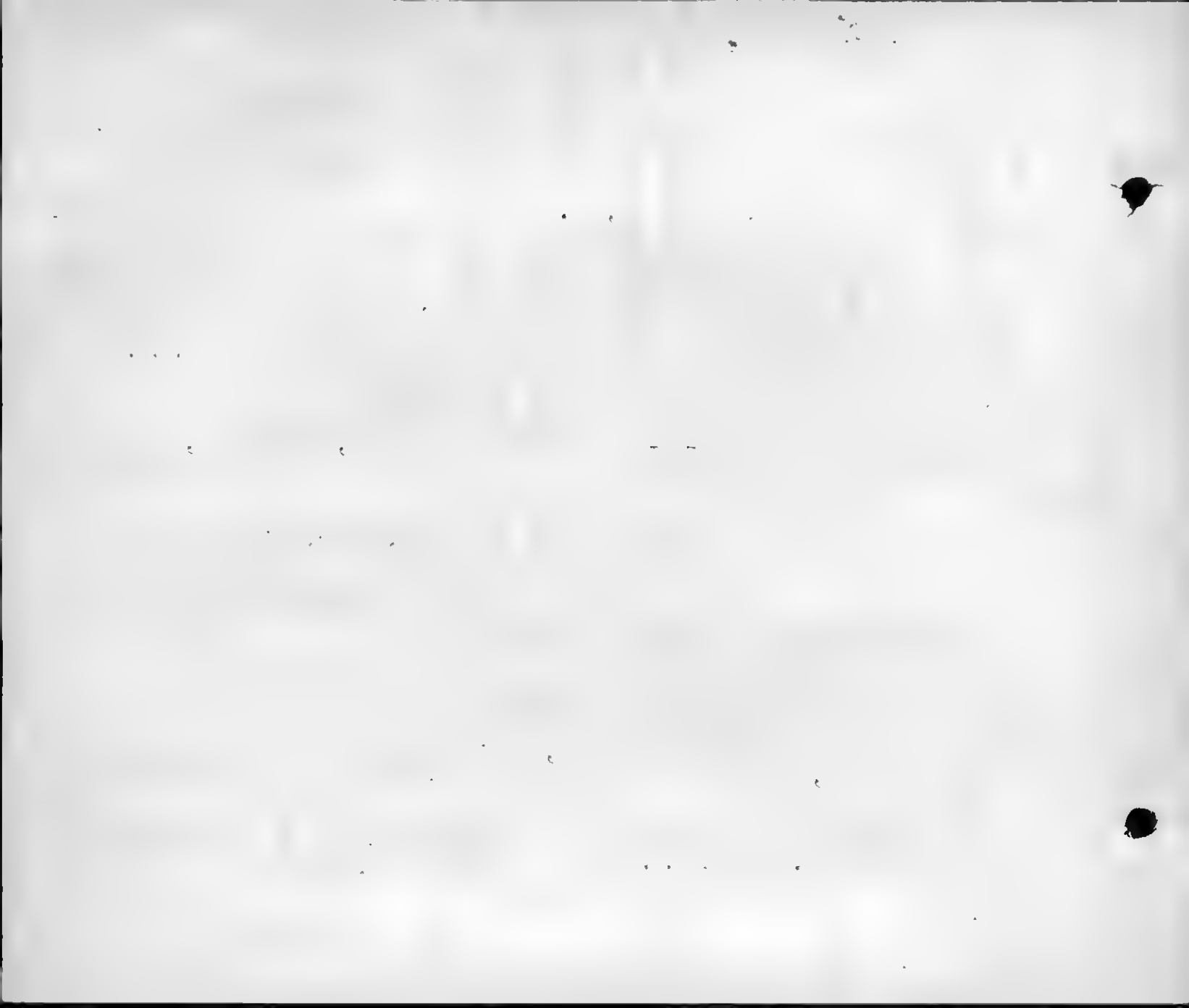
09281

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>34 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>South Charleston</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>213 Ninth Avenue</b> d. STREET ADDRESS <b>213 Ninth Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Dolph McCloud</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>August 13 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1898</b>
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Radiator Shop Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McCloud</b>		14. MOTHER'S MAIDEN NAME <b>Martha Drummond</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>236-07-9787</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pleural effusions</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma of pleurae, lungs, &amp; lymph nodes</b> DUE TO (c) <b>Carcinoma of body of pancreas</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Miliary granulomatous disease of liver and spleen</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1959</b> to <b>August 13, 1959</b> , that I last saw the deceased alive on <b>August 13, 1959</b> , and that death occurred at <b>6:00P</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 8/14/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Charles E. Mengel</b>		M. D. <b>Charles E. Mengel, M.D.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>	22b. DATE THEREOF <b>8-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>South Charleston, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey - Bethesda 14, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages-1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9326

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Urban</u>				d. STREET ADDRESS <u>9810 Summit Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Electa</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 21, 1899</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Sloat</u>				14. MOTHER'S MAIDEN NAME <u>Lary Miner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Kensington, Md.</u> <u>Glenn A. Middleton 9810 Summit Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-15-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Haffell</u>				ADDRESS <u>475-4-2171</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			



9327

## CERTIFICATE OF DEATH

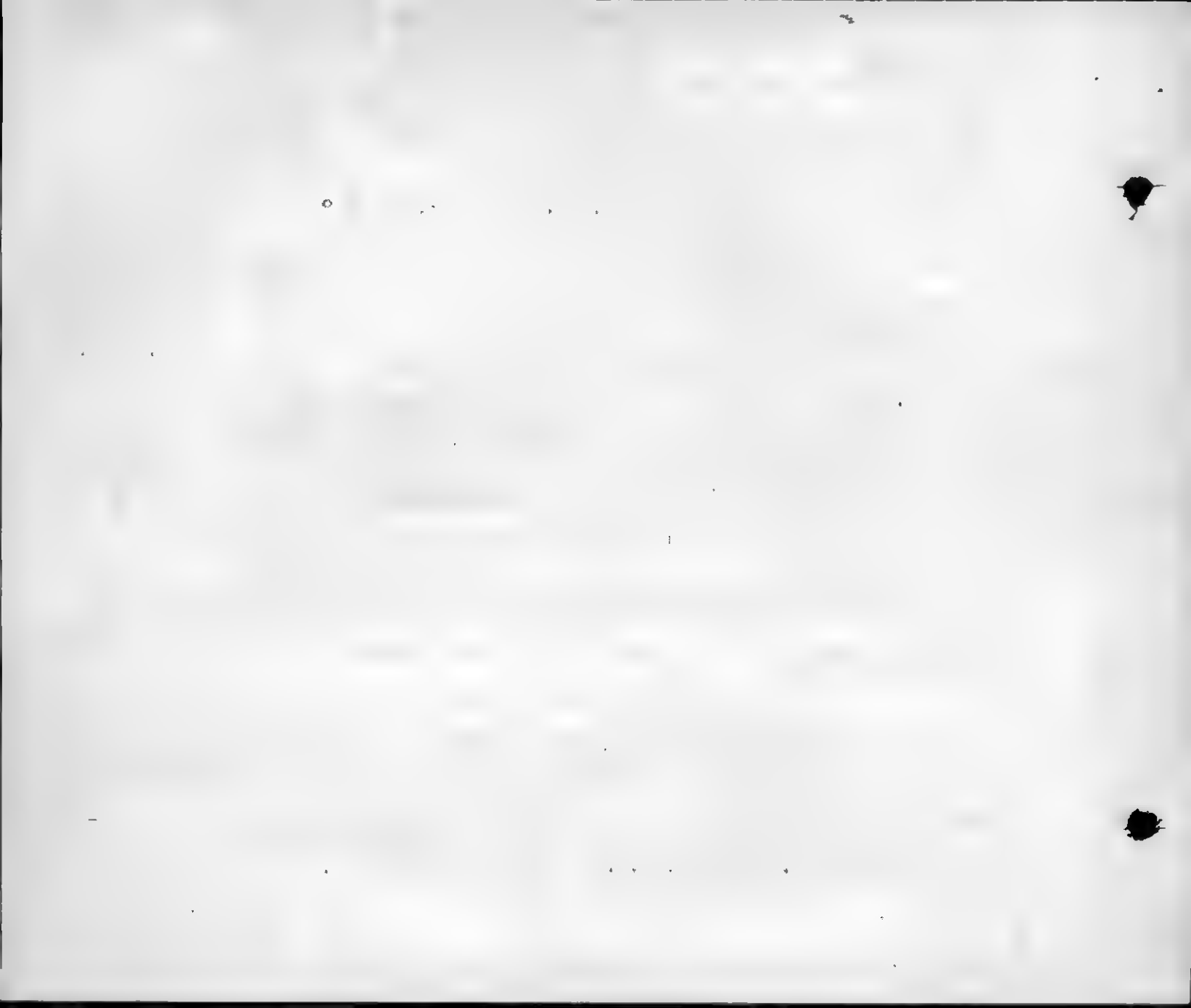
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY	
c. LENGTH OF STAY IN TB <b>54 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Biloxi</b>		d. STREET ADDRESS <b>Route 2, Box 619</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Janet</b> Middle <b>Ruth</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1957</b>	9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Carl J. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Jean Sutton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into Abdominal Tumor</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Wilm's Tumor of Right Kidney</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>36 Hours</b> <b>4 Months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 1, 1959</b> to <b>August 24, 1959</b> , that I last saw the deceased alive on <b>August 24, 1959</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Richard C. Mechanic</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>8-25-59</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>		<b>National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>8/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Quitman, Mississippi</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9328

CERTIFICATE OF DEATH

Reg. Dist. No.

09284

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MONTGOMERY</b> b. COUNTY <b>47X-3</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MO PINE Nursing Home</b>		d. STREET ADDRESS <b>1515 2404 St. SE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise J. Mitchell</b>		4. DATE OF DEATH Month Day Year <b>Aug 23 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 12-1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY C. Lehmann</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Nursing Home Records</b>		Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Accident</b> DUE TO <b>221X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Accident</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 + hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Run</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bethesda Post and</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1, 1957</b> to <b>Aug 23, 1959</b> , that I last saw the deceased alive on <b>Aug 23, 1959</b> , and that death occurred at <b>9:10 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9702 A Columbia Rd Bethesda 14 Md</b> DATE SIGNED <b>—</b>			
ACTUAL SIGNATURE <b>William H Killax</b> M.D.			
PHYSICIAN'S NAME (Type) <b>William H Killax</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Landover Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros.</b>		24a. REC'D BY REGISTRAR <b>1661-6000 Howard St Wash 20 D C</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9217

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Suburban Hospital</u>				d. STREET ADDRESS <u>Y.F. 10F. Norwich Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Frances</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>FE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 10, 1919</u>	
9. AGE (In years, last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Edward Daniel Moore</u>				14. MOTHER'S MAIDEN NAME <u>Connie Jean Dragan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>M. Blaser</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>ILLNESS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 10, 1959</u> , to <u>Aug. 10, 1959</u> , that I last saw the deceased alive on <u>Aug 10, 1959</u> , and that death occurred at <u>7:15p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.				ADDRESS (Street, city or town, state) <u>927 Pershing Drive Silver Spring Md.</u> DATE SIGNED <u>8/10/59</u>			
PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN, M.D.</u>				(same)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Quittell Walters</u> ADDRESS <u>254 Carroll St</u>				24a. REC'D BY REGISTRAR <u>J. Quittell Walters</u> DATE <u>8-11-59</u>		24b. REGISTRAR'S SIGNATURE <u>J. Quittell Walters</u>	

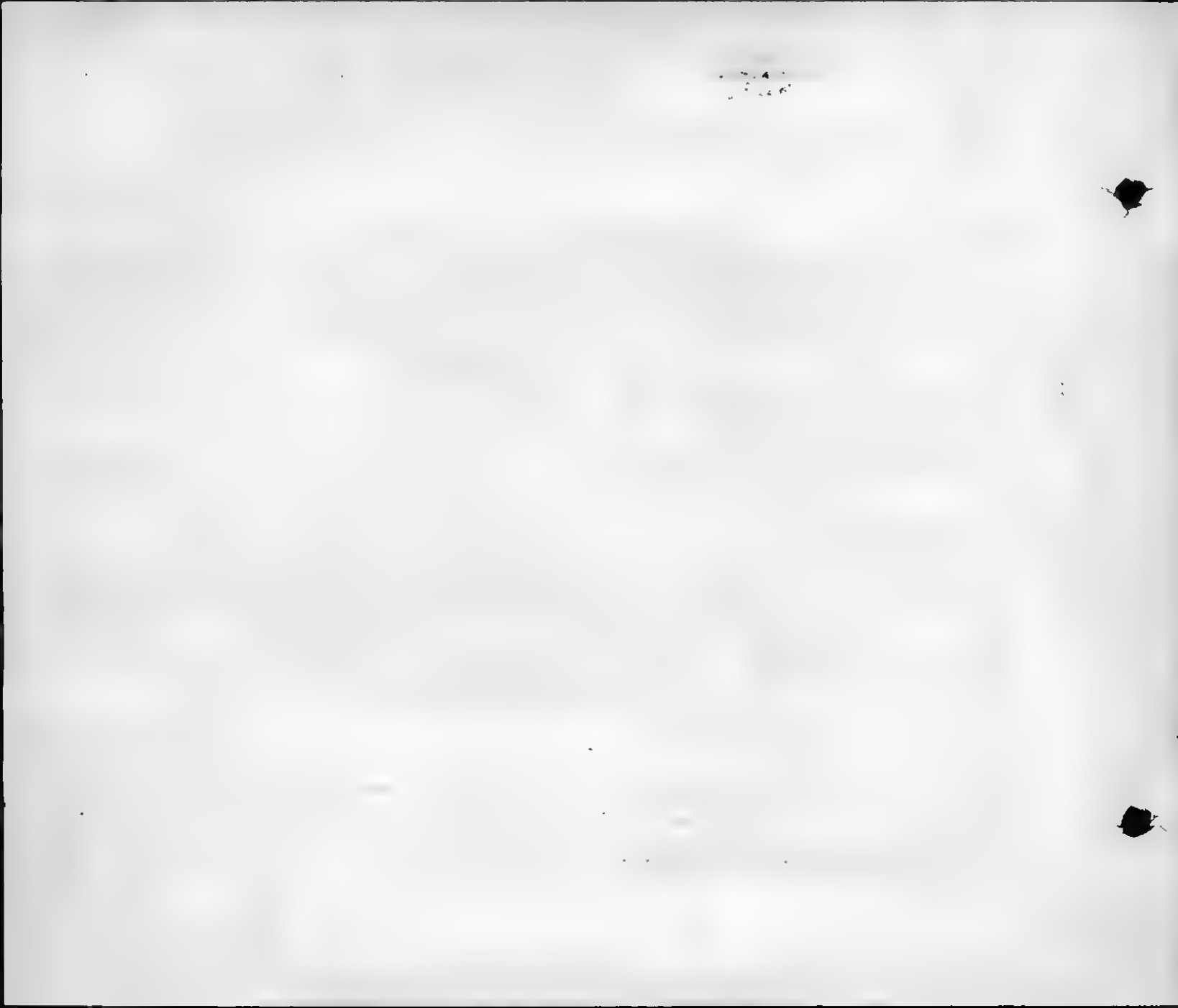
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AUG 13 '59

Curtis L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 9286

9218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> d. STREET ADDRESS <b>7620 Maple Avenue, Apt. 318</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Morrison</b>		4. DATE OF DEATH Month Day Year <b>August 23 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22 1959</b>
9. AGE (In years last birthday) yrs <b>19</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Billy Ray Morrison</b>		14. MOTHER'S MAIDEN NAME <b>Natalie Elizabeth Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage</b> <b>760.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cause undetermined</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>17 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/22/1959</b> to <b>8/23/1959</b> , that I last saw the deceased alive on <b>8/22/1959</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell B. Arnold M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>8801 Colesville Road, Silver Spring, Md. 8/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D.</b>		<b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Takoma Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		ADDRESS <b>Washington Sanitarium and Hospital, Takoma Park, Maryland</b>	

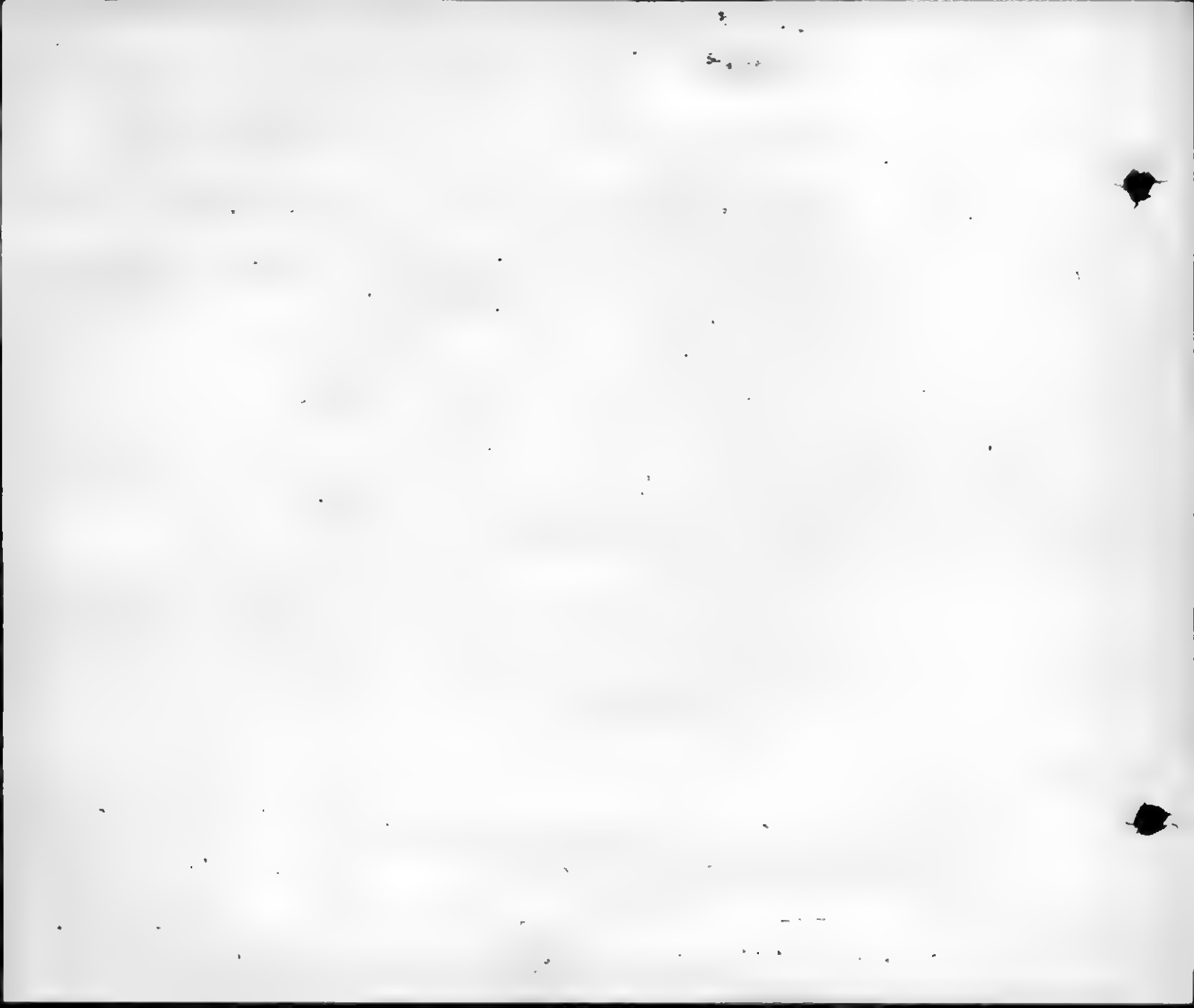
2075191XV4

SEP 3 '59

Arthur S. Hare

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



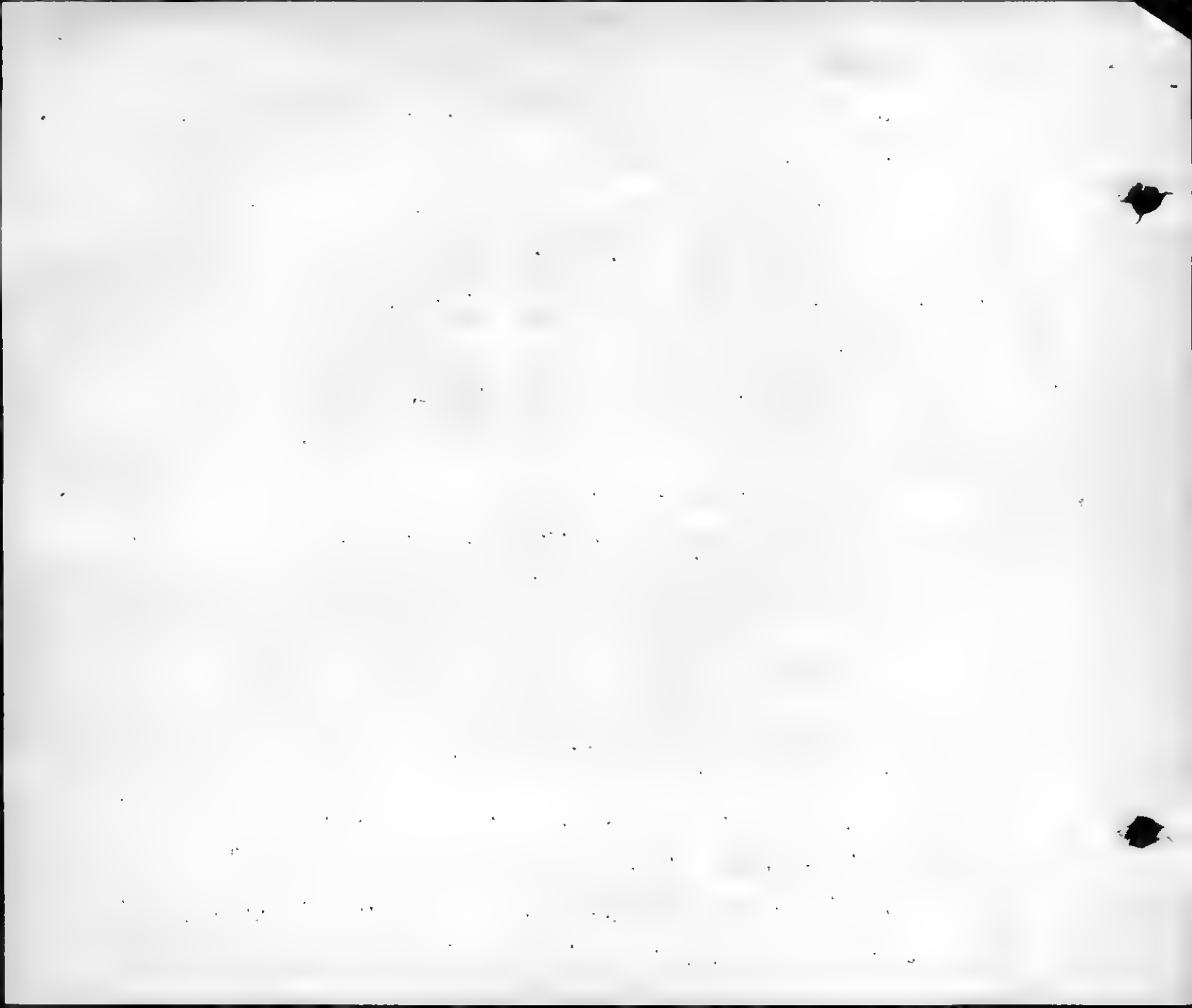
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS - 7 HRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>103 CALVERT ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>OTIS</b> Last <b>MORTON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-1885</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INTERNAL REVENUE</b>	
11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS J. MORTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY HAZEL WOOD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MAE P. MORTON (WIFE) SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> <b>451X</b> DUE TO <b>Ruptured abdominal Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerosis</b> (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 3, 1959, to Aug. 12, 1959</b> that I last saw the deceased alive on <b>Aug. 12, 1959</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Bowditch Hunter</b> M.D.		ADDRESS (Street, city or town, state) <b>309 Weirs Mill Road</b> DATE SIGNED <b>5/6/59</b>	
PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter</b>		<b>Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>8-8-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lynon Wheeler</b>		24a. REC'D BY REGISTRAR <b>Ind</b> DATE <b>AUG 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



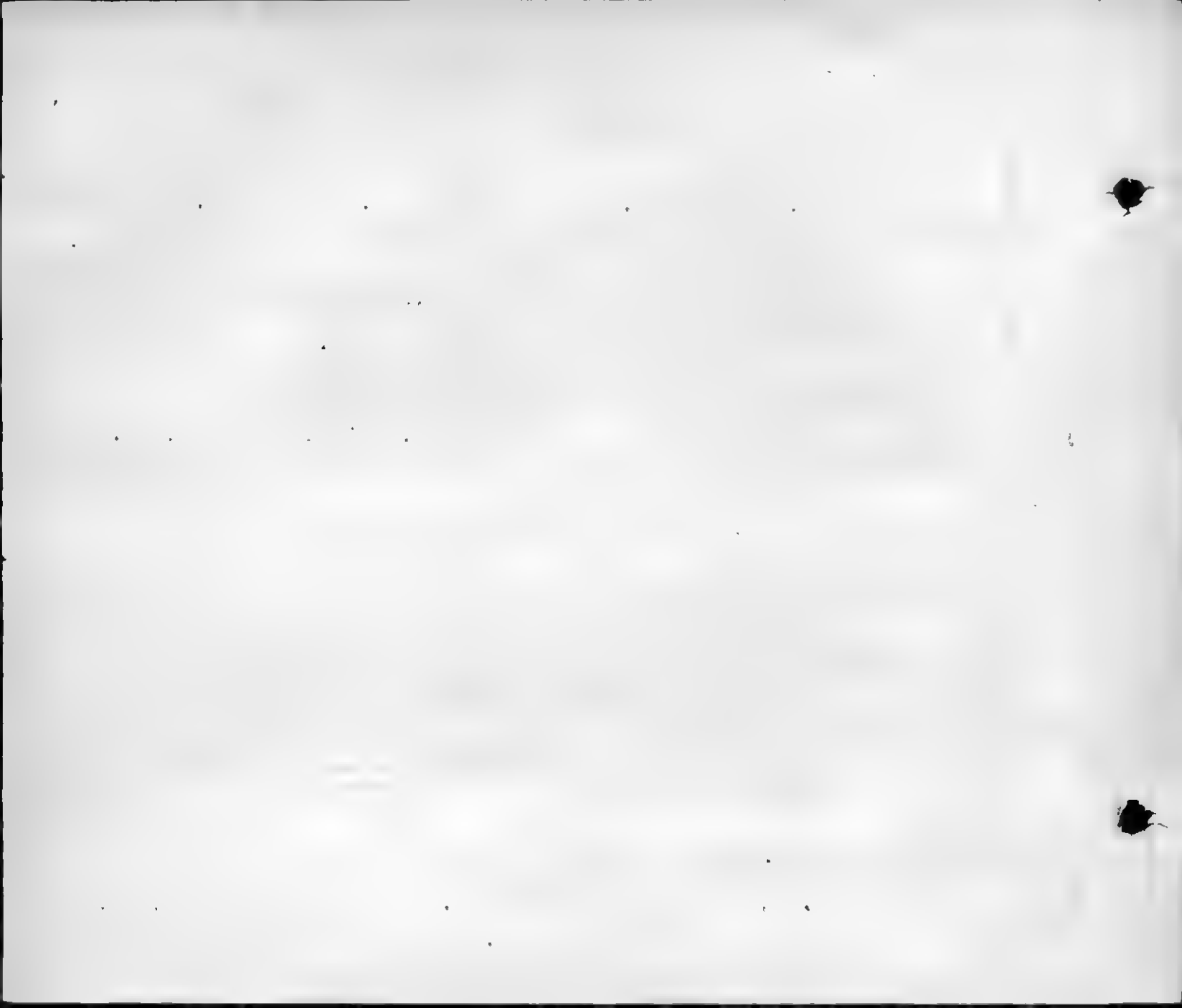
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>26023 Mt. Vernon Ave.</b>		d. STREET ADDRESS <b>26023 Mt. Vernon Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eleanor Hyatt Moxley</b>		4. DATE OF DEATH Month Day Year <b>August 17 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1878</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kempton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli Hyatt</b>		14. MOTHER'S MAIDEN NAME <b>Georganna Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Carl A. Cline, Monrovia, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inter-arterial coronary atherosclerosis</b> <b>422.1</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. [City or town] (County) (State)
21. I certify that I attended the deceased from <b>11/16</b> , 19 <b>59</b> , to <b>8/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>8-18-59</b> ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>	22d. LOCATION (City, town, or county) (State) <b>Clagettville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thomas</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9331

## CERTIFICATE OF DEATH

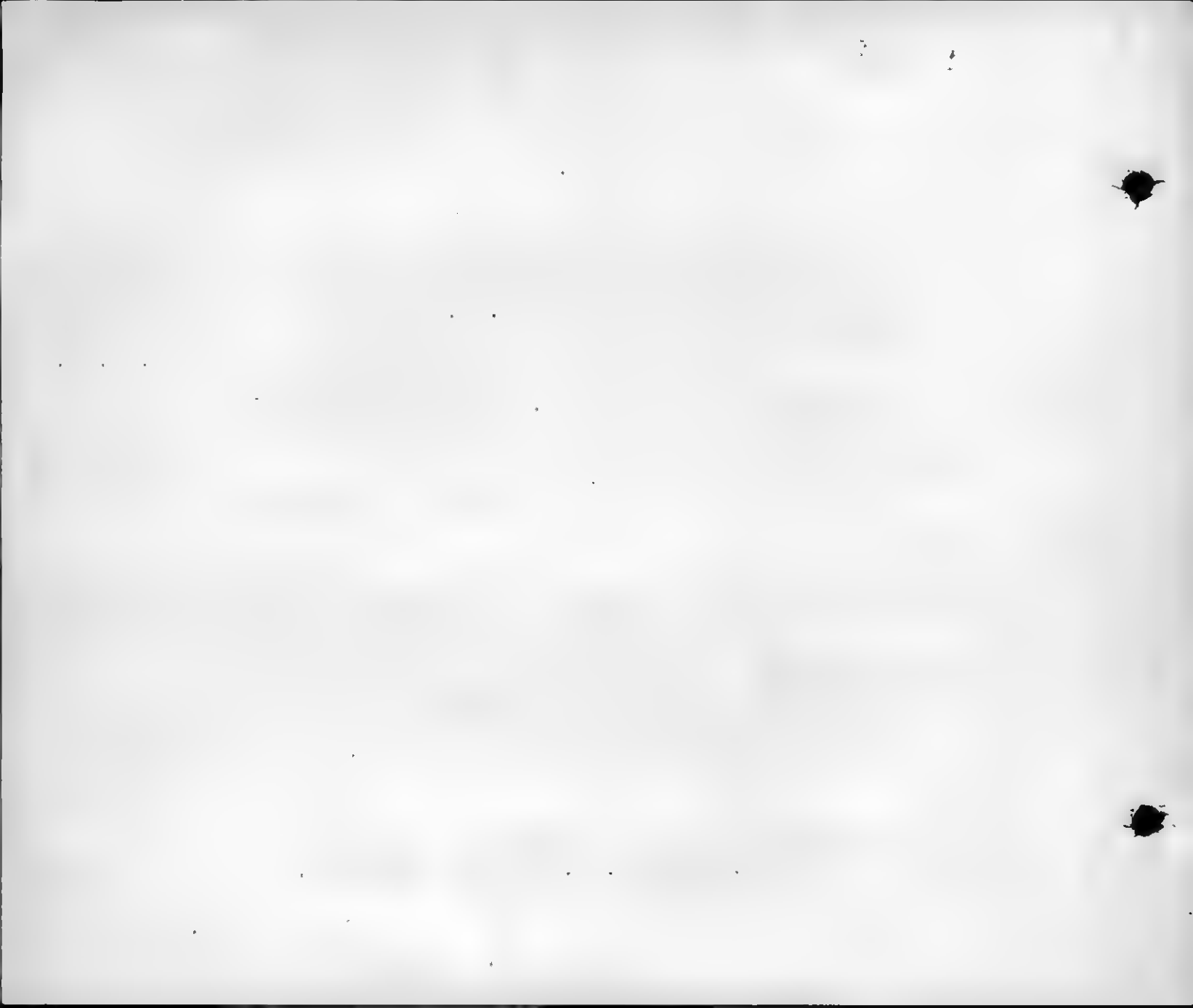
09289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>20 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>2200 Woodfield Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Ann</u> Last <u>Mullineaux</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8.22.59</u>
9. AGE (In years last birthday) yrs <u>20</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Aubrey Purdum Mullineaux, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lee Gladhill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>hospital records</u>	
17. INFORMANT <u>hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Cerebral Hemorrhage</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/22</u> 19 <u>59</u> , to <u>8/23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8/23</u> 19 <u>59</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr, M. D.</u>		DATE SIGNED <u>8/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrman</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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9332

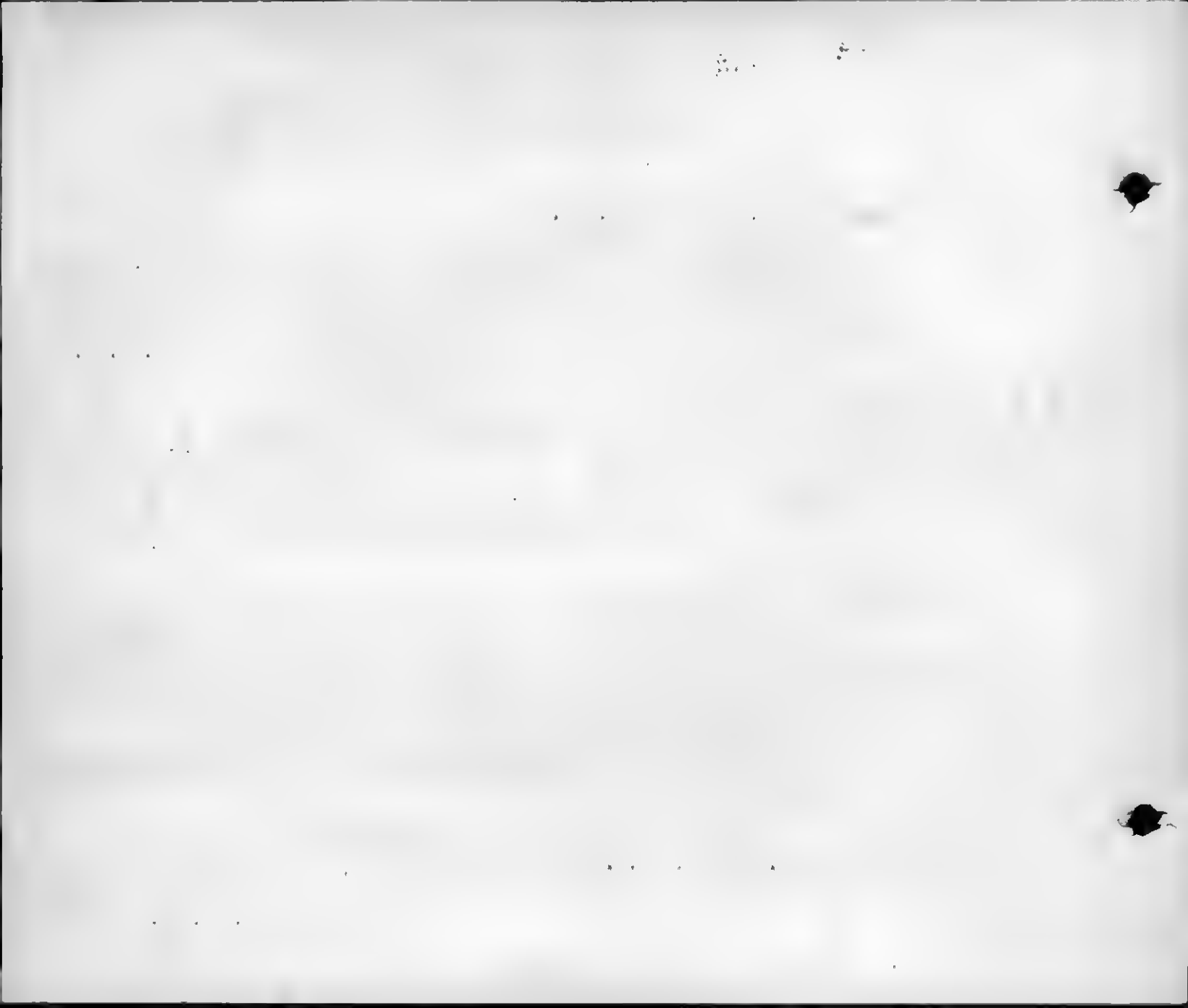
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09290

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>6528 79th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Aloysius</b>		First <b>(none)</b>		Middle <b>Neidert</b>		Last	
4. DATE OF DEATH <b>August 5, 1959</b>		Month <b>August</b>		Day <b>5,</b>		Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 25, 1906</b>	
9. AGE (In years lost birthday) yrs <b>53</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Neidert</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>45</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelocytic Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 1/2 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 29, 1959</b> to <b>August 5, 1959</b> , that I last saw the deceased alive on <b>August 5, 1959</b> , and that death occurred at <b>4:45 P.</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/6/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>				24. REC'D BY REGISTRAR DATE <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	







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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9333

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

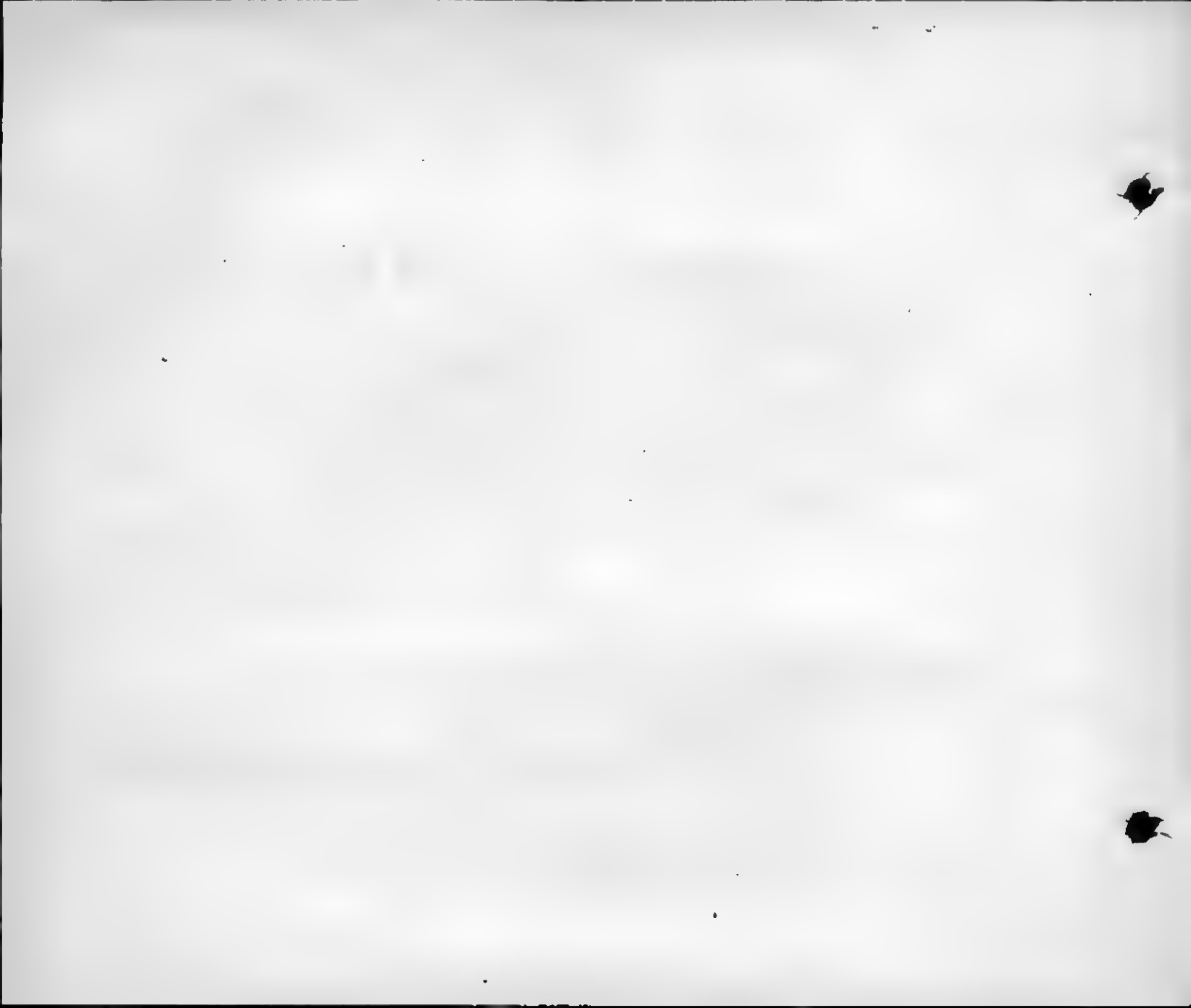
Items 8,9 Filled—B 9-16-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

09292

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>9 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2627 WEISSMAN ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>BROWN</b> Last <b>NICHOLSON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>27</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/13/88 4/18/89 7/17/70</b>	9. AGE (In years last birthday) <b>70</b> yrs	IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>59</b> Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>WILLIAM H. NICHOLSON</b>			14. MOTHER'S MAIDEN NAME <b>CAROLINE YOUNG</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS,</b> Address <b>OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA WITH ABSCESS FORMATION</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF LUNGS</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>ARTERIOSCLEROTIC HEART DISEASE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <b>AUGUST 18</b> , 19 <b>59</b> , to <b>AUGUST 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>AUGUST 26</b> , 19 <b>59</b> , and that death occurred at <b>12:07A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) <b>J. W. BIRD, M. D.</b>		M.D. <b>SANDY SPRING, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 29 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>			
23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE 			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

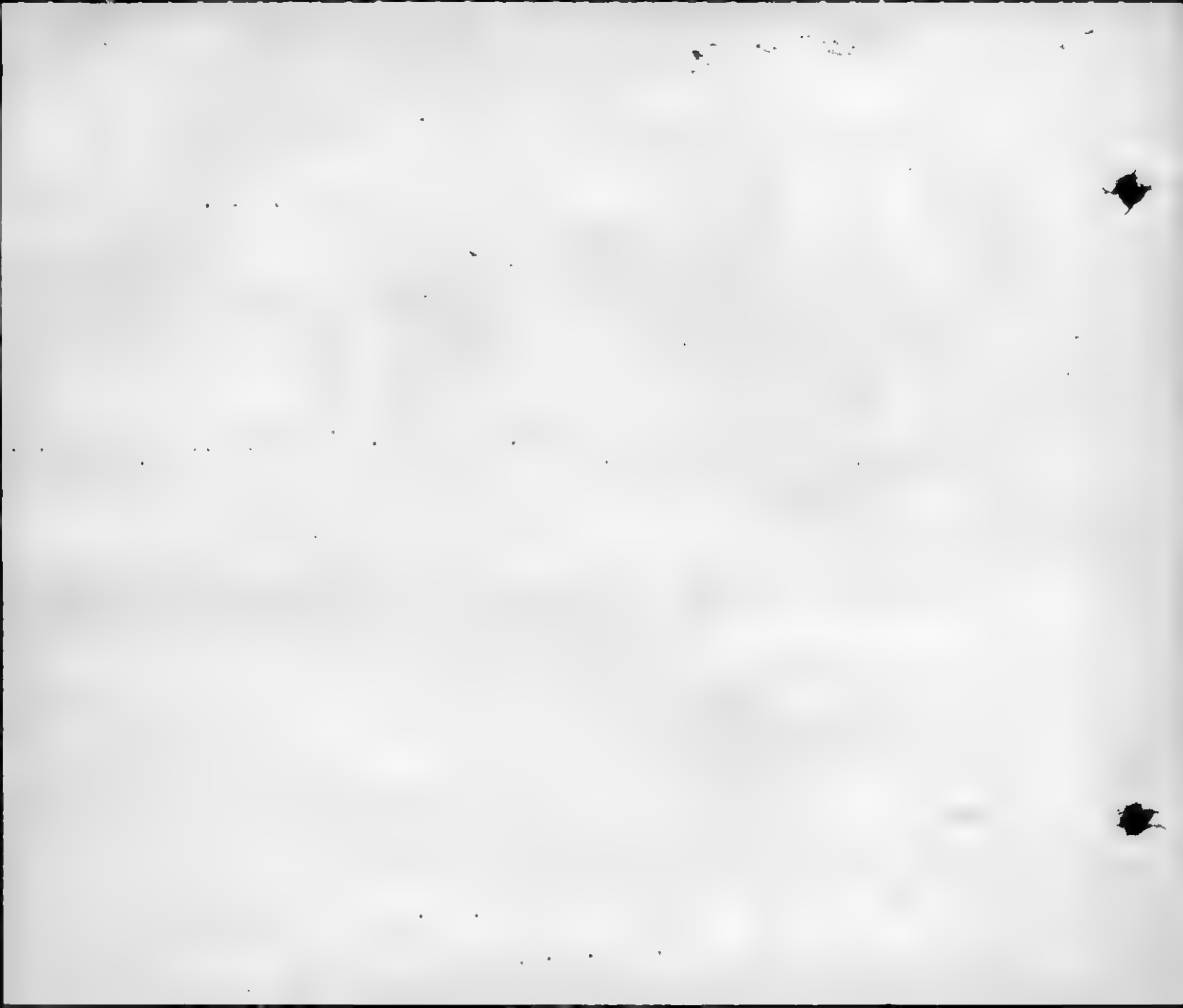
9334

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 3 Will 246 8-17-59 et  
**CERTIFICATE OF DEATH**

09293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARYLANDER NURSING HOME</b>		d. STREET ADDRESS <b>2205 California St., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Keturah</b> Middle <b>FOULDS</b> Last <b>O'BRIEN</b>		4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK FOULDS</b>		14. MOTHER'S MAIDEN NAME <b>MARY BLAIR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>COL. ROBERT E. O'BRIEN, JR., ROSWELL, N.M.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intermittent cardiovascular disease</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/19</b> , 19 <b>59</b> , to <b>8/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/13</b> , 19 <b>59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Kerr</b>		DATE SIGNED <b>8/13/59</b>	
PHYSICIAN'S NAME (Type) <b>James G. Kerr</b>		M.D. <b>D. M. S. C. 45 M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>FORT MYER, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph ...</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9335

## CERTIFICATE OF DEATH

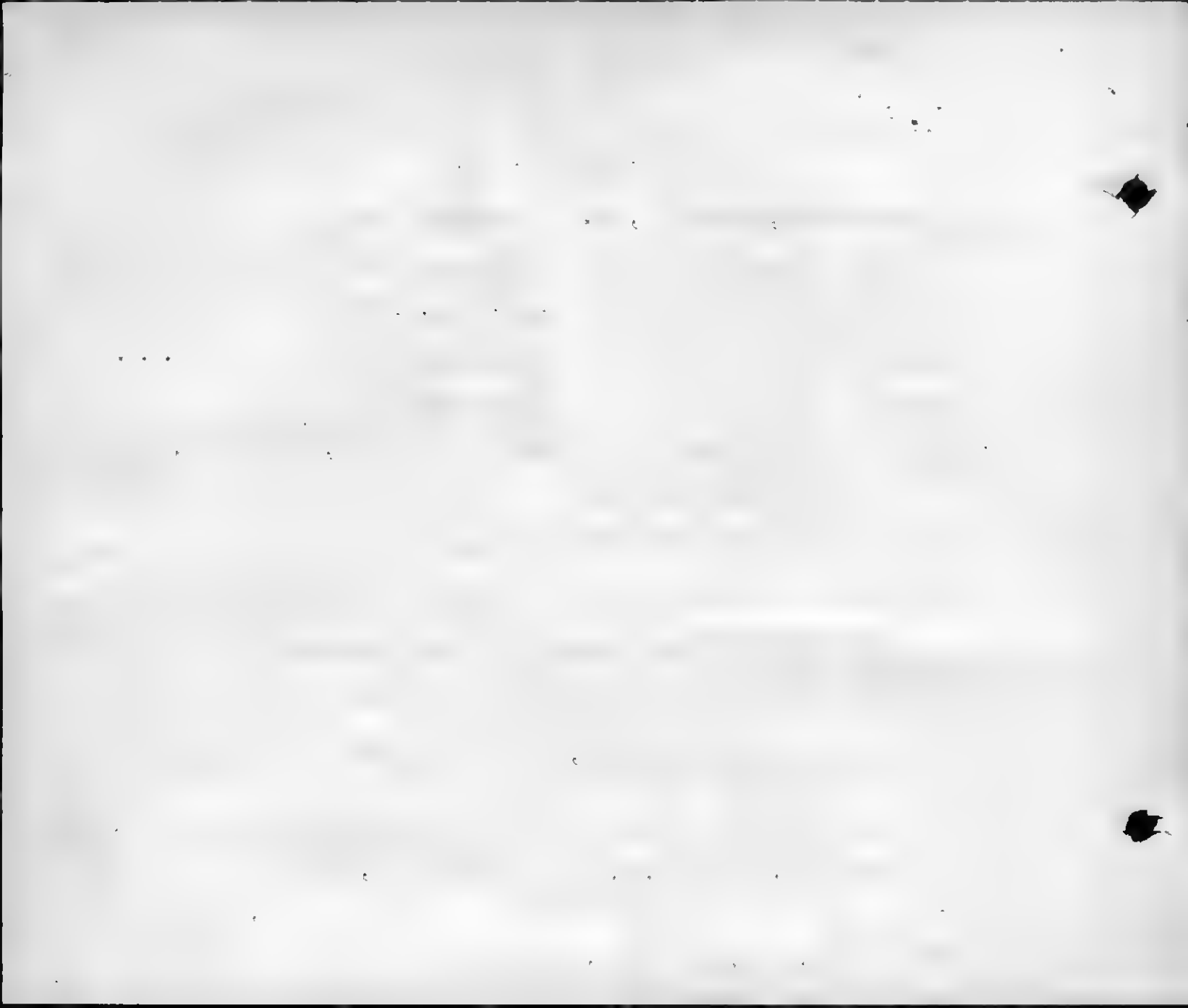
09294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>5 Shetland Court</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lillian Nancy Oliverio</b>	4. DATE OF DEATH <b>August 13 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS <b>Days</b>	<b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Leon Casella</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Reale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Adenocarcinoma, Liver</b> DUE TO (c) <b>Adenocarcinoma, Sigmoid Colon</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypercholesterolemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 7, 1959</b> , to <b>August 13, 1959</b> , that I last saw the deceased alive on <b>August 13, 1959</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-14-59</b>	
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, or other disposal of body <b>Burial-transit 8-14-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 18 59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Mengel</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9336

## CERTIFICATE OF DEATH

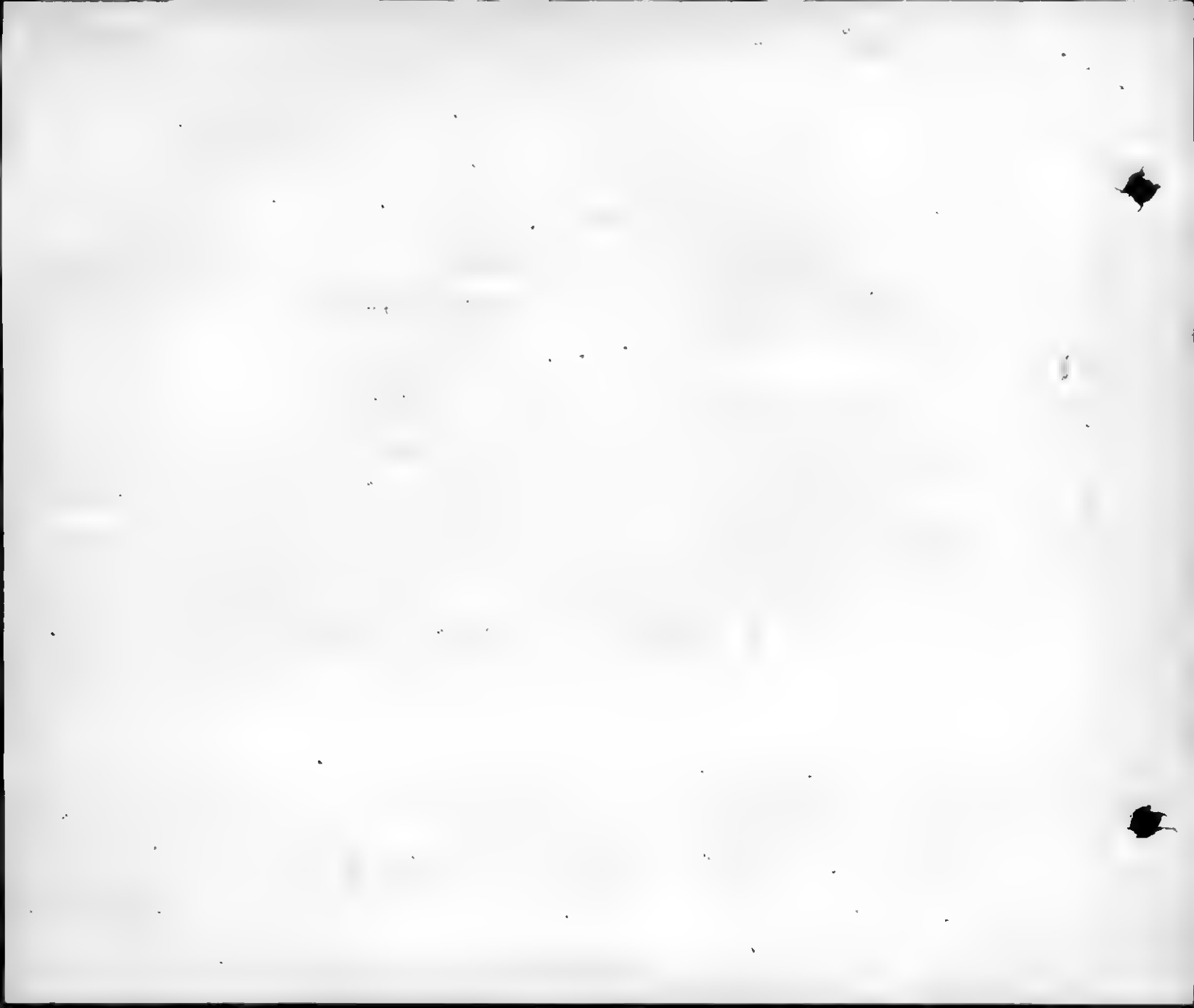
Reg. Dist. No.

09295

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>KENSINGTON GARDENS NURSING HOME</u>				e. STREET ADDRESS <u>5414 HUNTINGTON PKWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Roscoe</u> Last <u>Pastor</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 18, 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Hospital records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO <u>ADVANCED CEREBRAL VASCULAR ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>CHRONIC PYELONEPHRITIS; PROSTATIC HYPERTROPHY</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 YEARS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JULY</u> 19 <u>55</u> , to <u>Aug 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 23</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>9420 OLD GEORGETOWN RD</u> <u>Aug 23, 1959</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR MD</u>				BETHESDA 14, MARYLAND <u>1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bergen County, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film G247 8-27-59 et

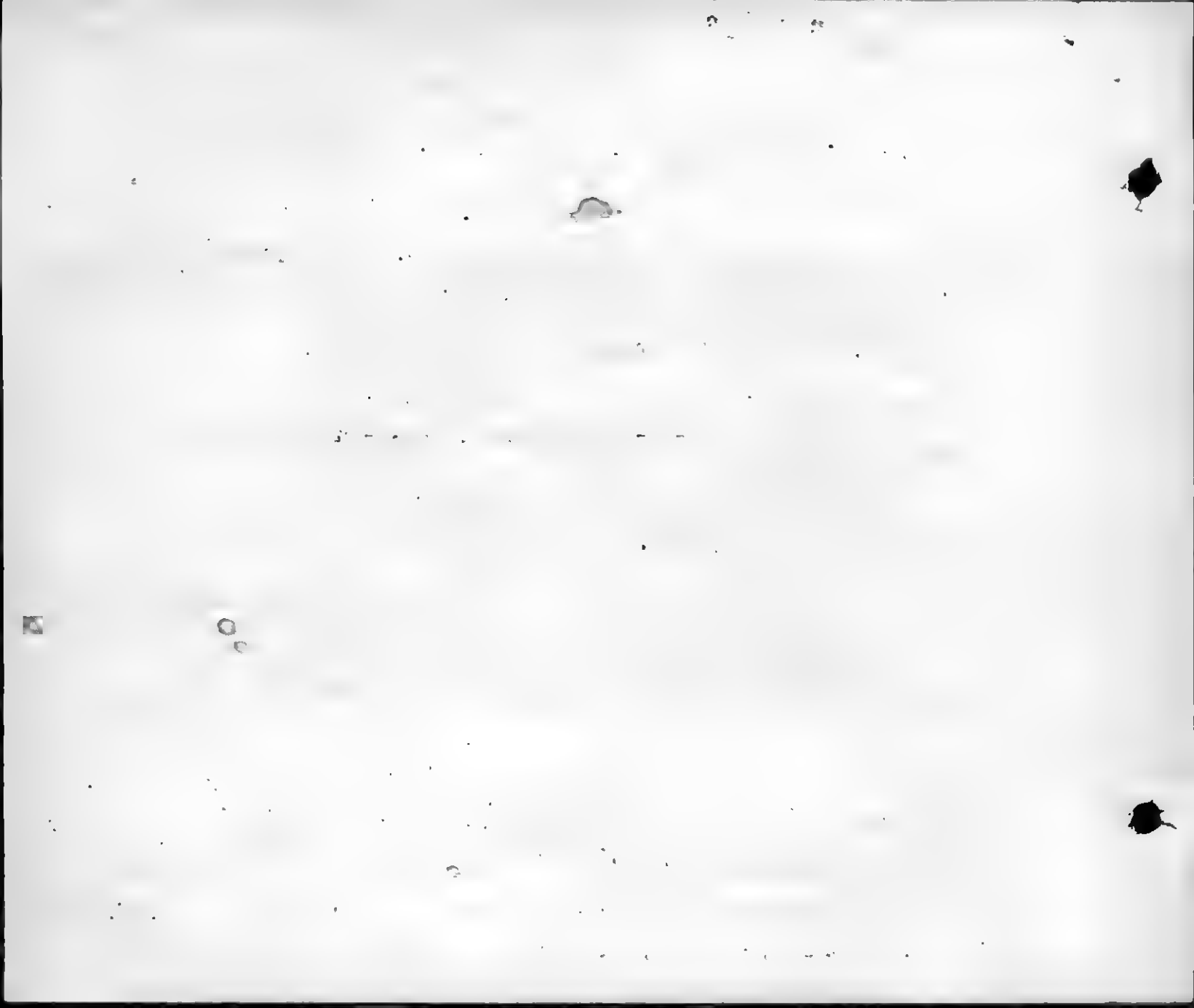
9337

## CERTIFICATE OF DEATH

09296

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md-Montgomery</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>5 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>9205 Burley Dr</u>			
3 NAME OF DECEASED (Type or print) First <u>Millard</u> Middle <u>E</u> Last <u>Peake</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-14-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. UNDER 1 YEAR <u>3</u> Months <u>7</u> Days		11. UNDER 24 HRS <u>7</u> Hours <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Millard Peake</u>				14. MOTHER'S MAIDEN NAME <u>Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-03-6700</u>		INFORMANT Address <u>Agnes L. Peake-Same Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Failure</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1948, to <u>Aug 21</u> , 1957, that I last saw the deceased alive on <u>Aug 21</u> , 1957, and that death occurred at <u>12:22 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Wardrop MD</u> M.D.				ADDRESS (Street, city or town, state) <u>837 Bonfant St. Silver Spring MD</u> DATE SIGNED <u>8/21/59</u>			
PHYSICIAN'S NAME (Type) <u>W.B. WARDROP MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	





9338

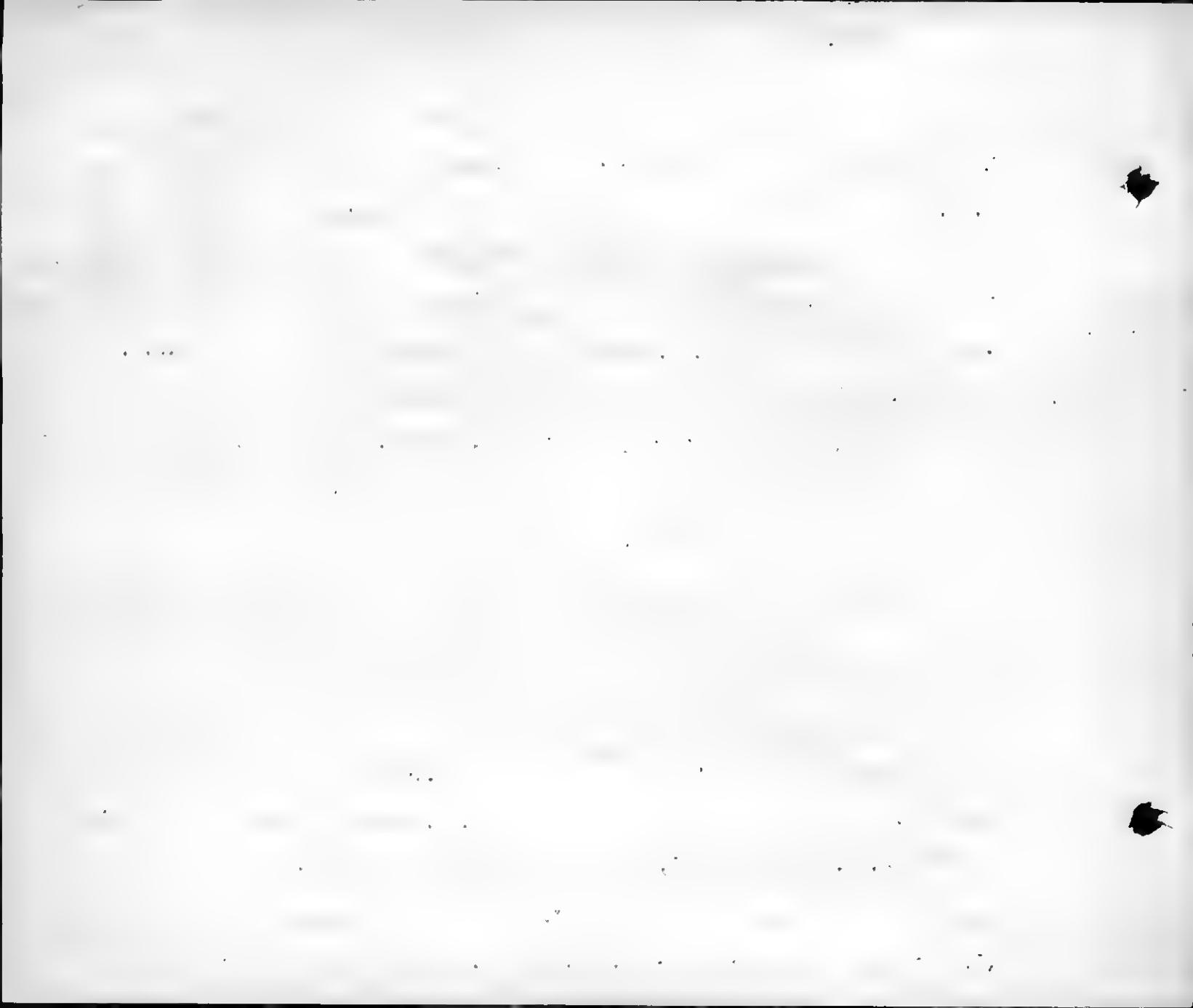
CERTIFICATE OF DEATH

Reg. Dist. No. 215

09297

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>40 min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>912 Gable Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Franklin PETERSON</b>		4. DATE OF DEATH Month Day Year <b>August 3 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-12</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank PETERSON</b>		14. MOTHER'S MAIDEN NAME <b>Hattie MOON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>546 30 1102</b>	
17. INFORMANT <b>(W) Mrs. Anna S. Peterson, same address as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 3</b> , 19 <b>59</b> , to <b>August 3</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 3</b> , 19 <b>59</b> , and that death occurred at <b>10:00PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 8-4-59</b>			
ACTUAL SIGNATURE <b>J. M. Young</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>J. M. YOUNG, LT, MC, USN</b>		<b>Bethesda 14, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Aug 7 '59</b>	
ADDRESS <b>8434 Ga. Ave., SS, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Pumphrey</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

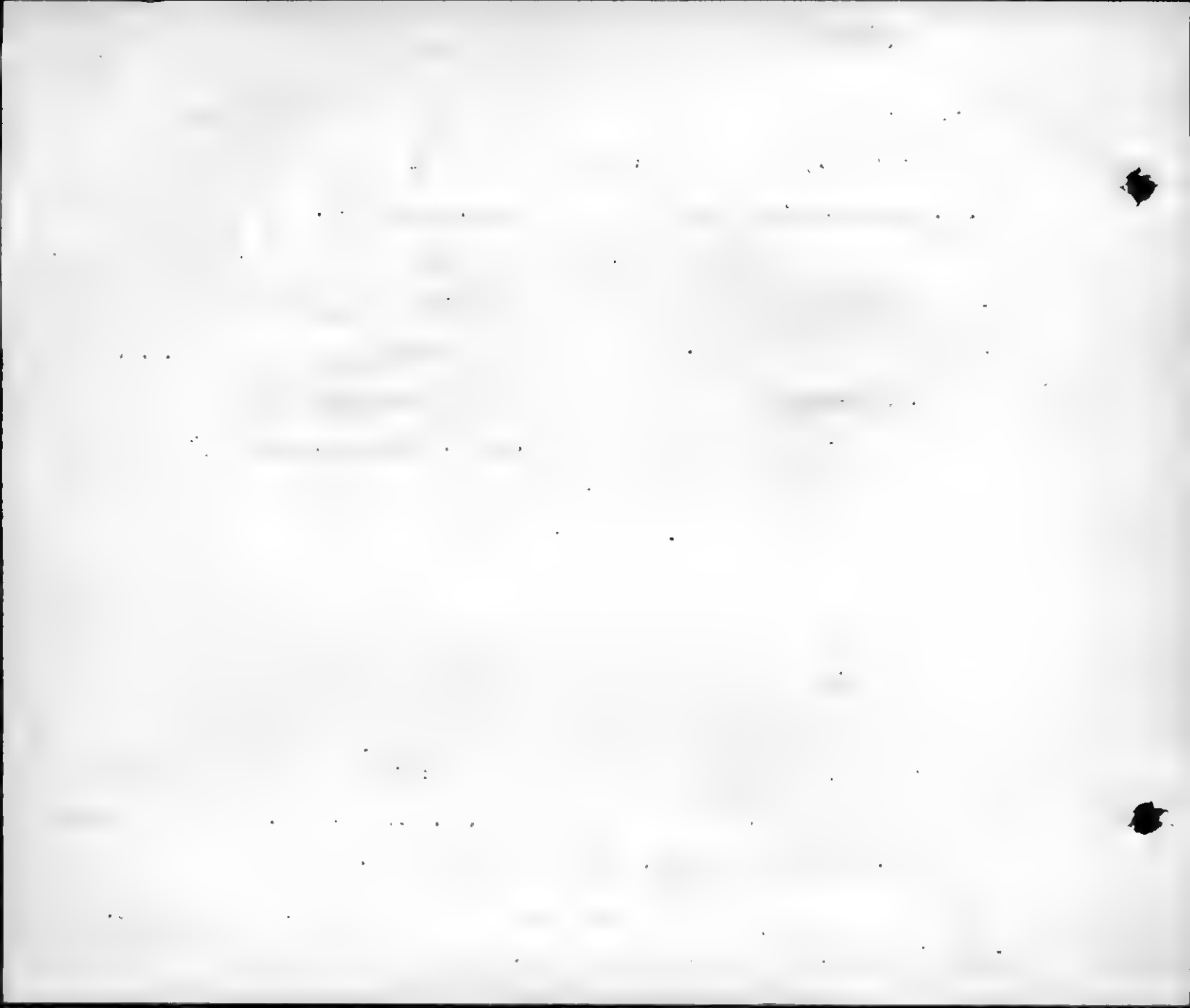
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 9339 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

09298

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>505 Marshall Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		3. NAME OF DECEASED (Type or print) First <b>Bruce</b>		Middle <b>Wade</b>		Last <b>PETTIJOHN</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>4</b>		Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-51</b>		9. AGE (In years last birthday) <b>7</b> yrs		IF UNDER 1 YEAR Months <b>7</b>		IF UNDER 24 HRS Days <b>4</b>		Hours <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Jack E. PETTIJOHN</b>		14. MOTHER'S MAIDEN NAME <b>Freda May GARNETT</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(F) Jack E. Pettijohn, same as #2</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>71X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>nephrosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>2 1/2 years</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>July 25</b> , 1959, to <b>August 4</b> , 1959, that I last saw the deceased alive on <b>August 4</b> , 1959, and that death occurred at <b>12:20 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>8-4-59</b>											
ACTUAL SIGNATURE <b>F. De Paola</b>		M.D.													
PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>		Bethesda, Maryland													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 7 59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Travis</b>									



FOR STATE  
HEALTH DEPT.

9340

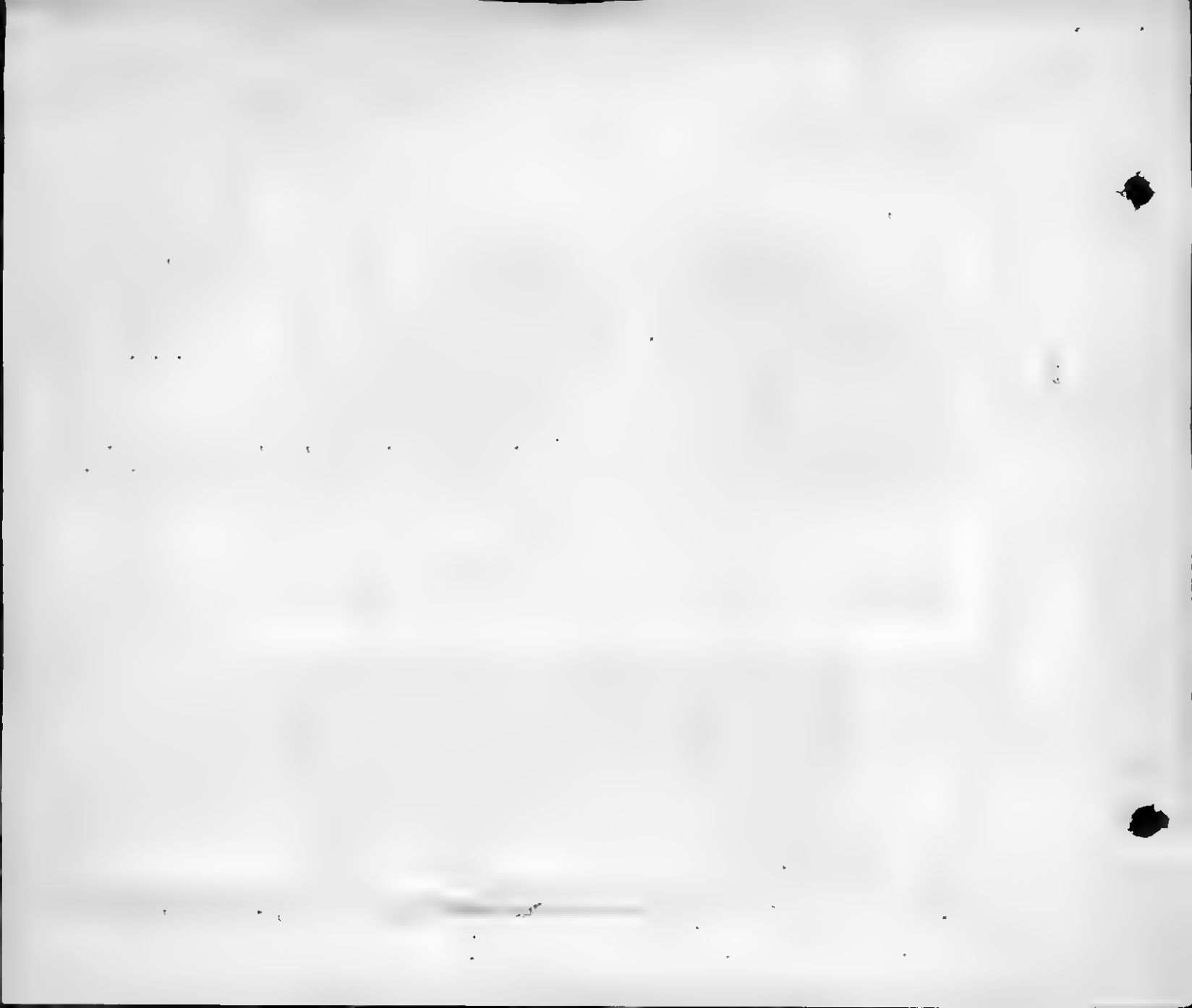
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09299

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY in 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11,711 GALT AVENUE</b>				e. STREET ADDRESS <b>8405 DIXON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH LEE PRAUP</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 24, 19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/71</b>		9. AGE (In years last birthday) <b>88</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress (alterations) Clothing stores</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>MERRITT</b>				14. MOTHER'S MAIDEN NAME <b>MARY OVERBY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT Address <b>Mrs. Blanche L. Moore, 11,711 Galt Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arterio-sclerosis</b> DUE TO (c) <b>hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
24a. REC'D BY REGISTRAR <b>AUG 26 '59</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9341

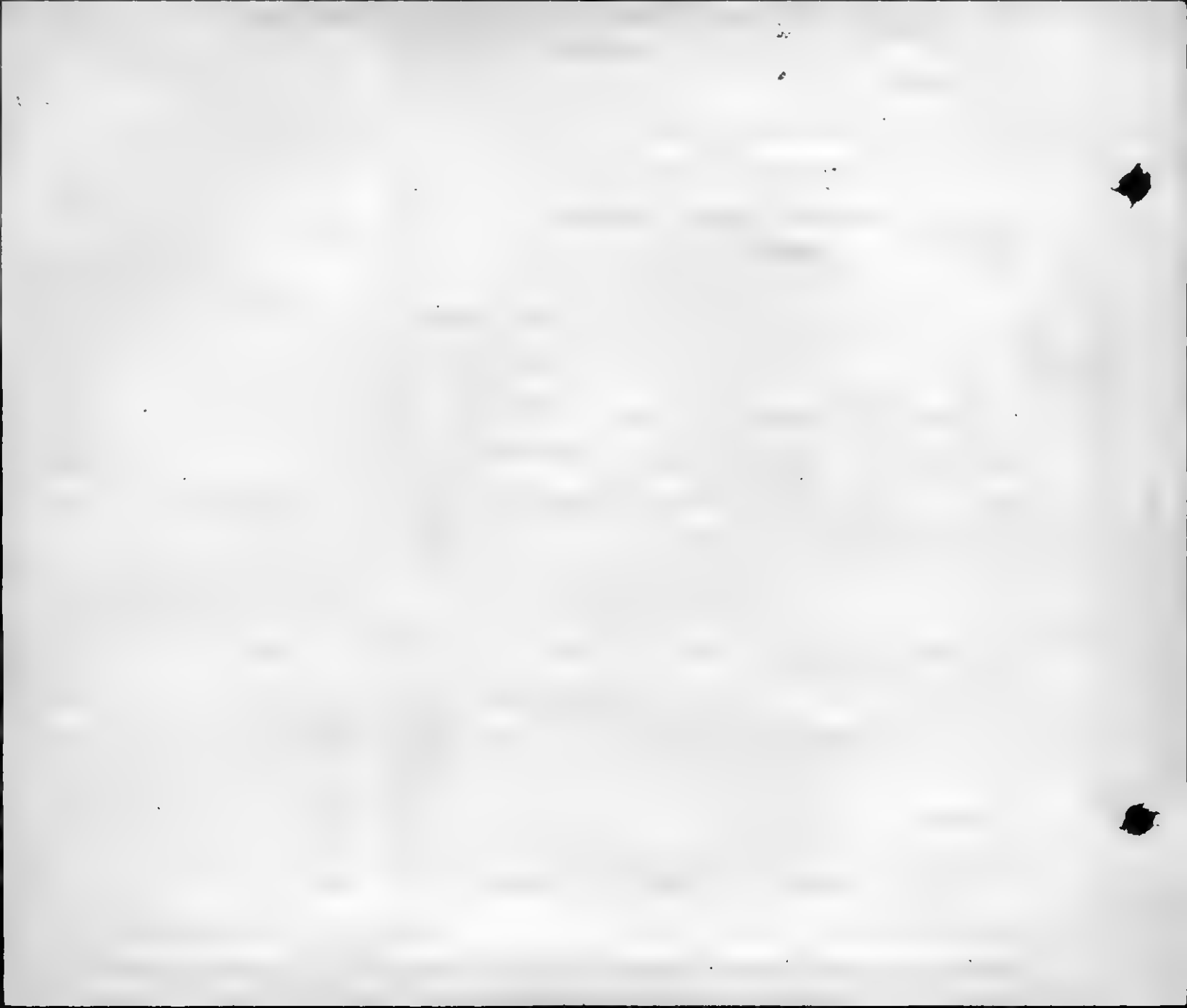
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09300

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Suburban Hospital</u> c. LENGTH OF STAY IN 1b <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Suburban Hospital, Bethesda, Md. #7-Therman Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SELENA</u> Middle <u>LAURA</u> Last <u>PHIPPS</u>	4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15-1969</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Peter Walters</u>		14. MOTHER'S MAIDEN NAME <u>Edna Harvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Olga Phipps #7 Therman Ave.</u>		Address <u>Sakoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>age (90 yrs)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adverse Complications of Labor - Intestinal Obst.</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>17</u> Year <u>1959</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 17, 1959</u> to <u>Aug 17, 1959</u> , that I last saw the deceased alive on <u>Aug 17, 1959</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H Scully</u> M.D. <u>1835 Ego St NW</u>		DATE SIGNED <u>Aug 16 P.C.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES H SCULLY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sakoma Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pine Bluff, Ark</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>





1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9342

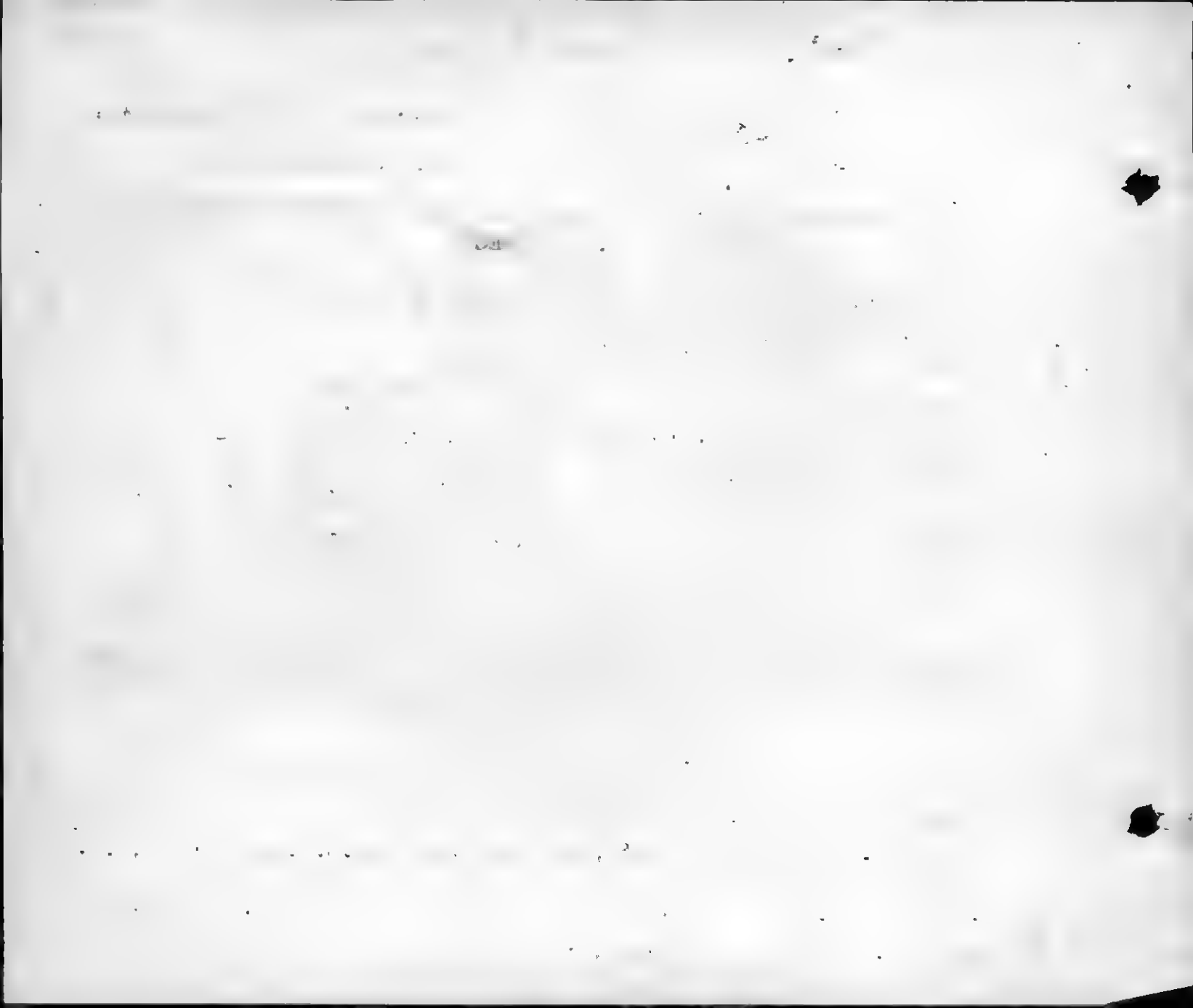
Item 16 Filed 9-3-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05301

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Pineallas</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3522 Raymond Street-</b>		d. STREET ADDRESS <b>P227 James Avenue, South</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>L.</b> Last <b>PIERCE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/1/1884</b>
9. AGE (In years last birthday) yrs <b>74</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>16</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12 CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>246-07-1334</b>	
17. INFORMANT <b>Magnolia E. Pierce-wife-same as item 2</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Antero-lateral myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1936</b> to <b>Aug 1959</b> , that I last saw the deceased alive on <b>8/14</b> , <b>1959</b> , and that death occurred at <b>1:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8/17/59</b>			
ACTUAL SIGNATURE <b>Arron Schwartzman</b> M.D.		DATE SIGNED <b>8/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Arron Schwartzman, 2007 Nicholas Ave. S.E. Washington, D.C.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	



9220

## CERTIFICATE OF DEATH

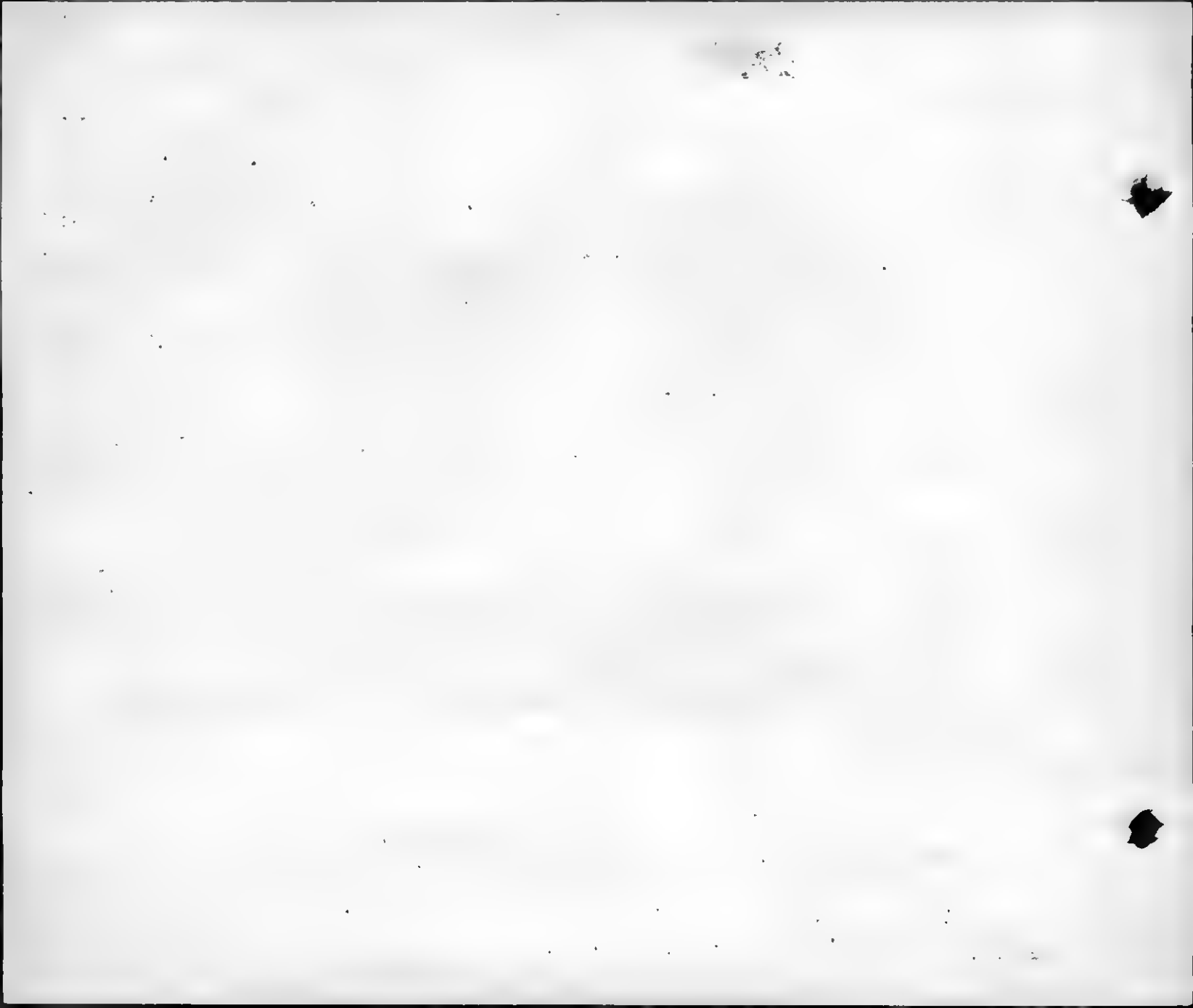
Reg. Dist. No.

09302

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>IRA DRYDEN PITTSER</u>		4. DATE OF DEATH Month Day Year <u>AUG. 17 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>known</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>known</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>	
13. FATHER'S NAME <u>William H. Pittenger</u>		14. MOTHER'S MAIDEN NAME <u>Maria Dryden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>known</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Berechnian</u> 4+ DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>8/17/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>59</u> , to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>E. A. Wolohan</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Chas. H. Wolohan</u>		DATE SIGNED <u>John Park</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George's Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St WDC</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. H.</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

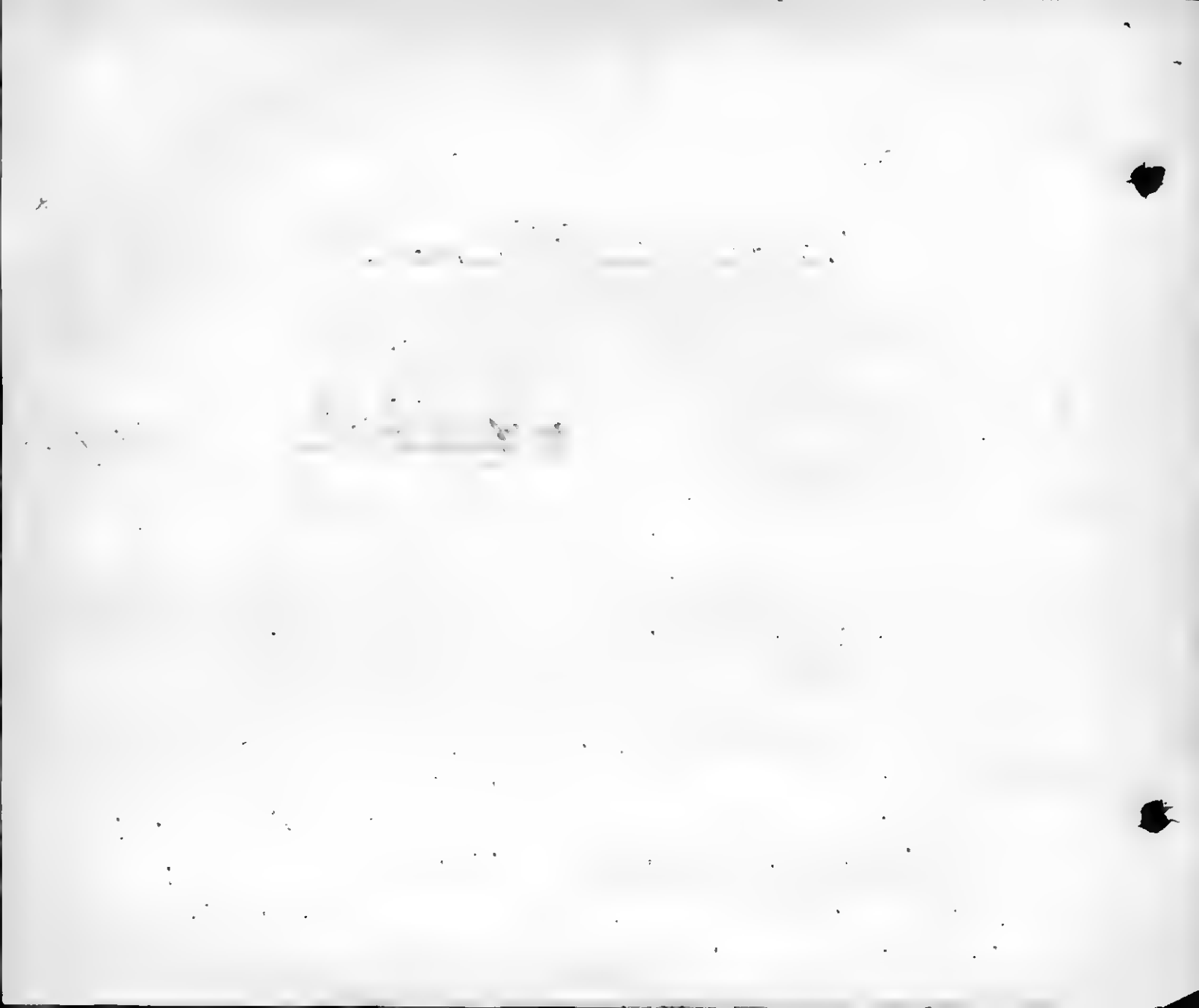
Item 8 Film 6246 8-24-59 et

## CERTIFICATE OF DEATH

09303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Manda</b> Middle <b>C</b> Last <b>Plummer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/88 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Hazel W Cashell</b>	
14. MOTHER'S MAIDEN NAME <b>Mary E Davis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>M. Elizabeth Plummer - daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA</b> DUE TO (c) <b>HYPERTENSIVE ATHEROSCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>2 DAYS</b> <b>20 YEARS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arrhythmia FIBRILLATION - NEPHROSIS &amp; LEROSIS</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUGUST 17, 1959</b> to <b>AUGUST 17, 1959</b> , that I last saw the deceased alive on <b>AUGUST 17, 1959</b> , and that death occurred at <b>720 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N. Summit Ave. Gaithersburg, Maryland</b> DATE SIGNED <b>August 19, 1959</b>			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b>		PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		24a. REC'D BY REGISTRAR <b>Aug 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Thoms</b>		24c. REGISTRAR'S SIGNATURE <b>Charles S. Thoms</b>	



## CERTIFICATE OF DEATH

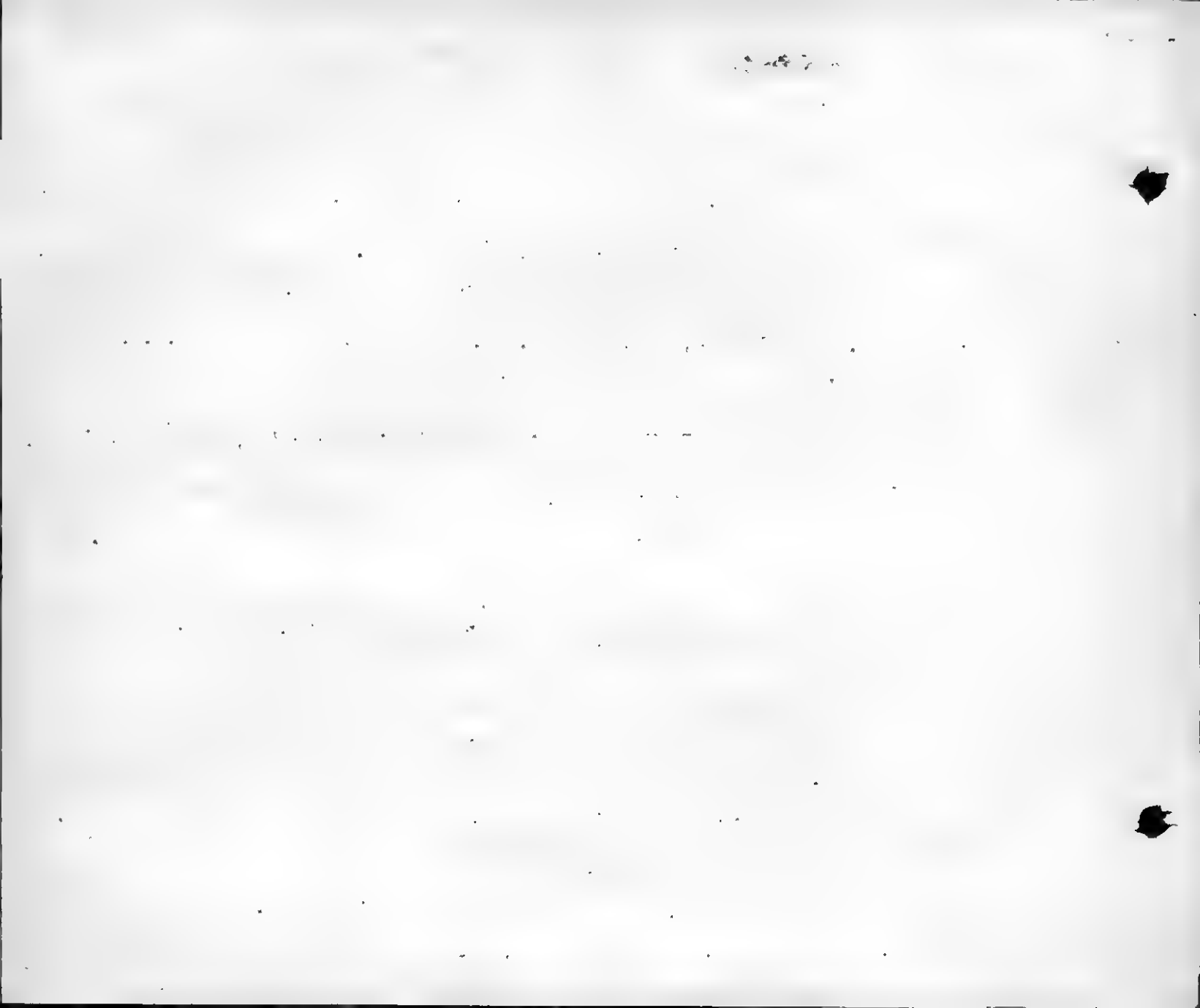
Reg. Dist. No.

9221

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANK</b> First <b>SALES</b> Middle <b>POHANKA</b> Last <b>SR</b>		4. DATE OF DEATH <b>Aug</b> Month <b>26</b> Day <b>1959</b> Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/29/91</b>
9. AGE (In years lost birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Pres. Auto Dealer, Pohanka Serv. Inc.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JULIUS POHANKA</b>		14. MOTHER'S MAIDEN NAME <b>ERNESTINE VOLYEAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-40-9720</b>	
17. INFORMANT <b>Mrs. Charlotte M. Pohanka</b>		Address <b>Burnt Mills Hills, Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral embolism with infarction of brain</b> DUE TO (b) <b>atherosclerosis of aorta</b> DUE TO (c) <b>Recent coronary Thrombosis with infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-1</b> 19 <b>59</b> to <b>8-26</b> 19 <b>59</b> that I last saw the deceased alive on <b>Aug 26</b> 19 <b>59</b> , and that death occurred at <b>1215 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4201 New Hampshire NW</b> DATE SIGNED <b>8/26/59</b>	
ACTUAL SIGNATURE <b>Chas. W. Harnsberger</b> M.D.		PHYSICIAN'S NAME (Type) <b>CHAS. W. HARNBERGER</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>8/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

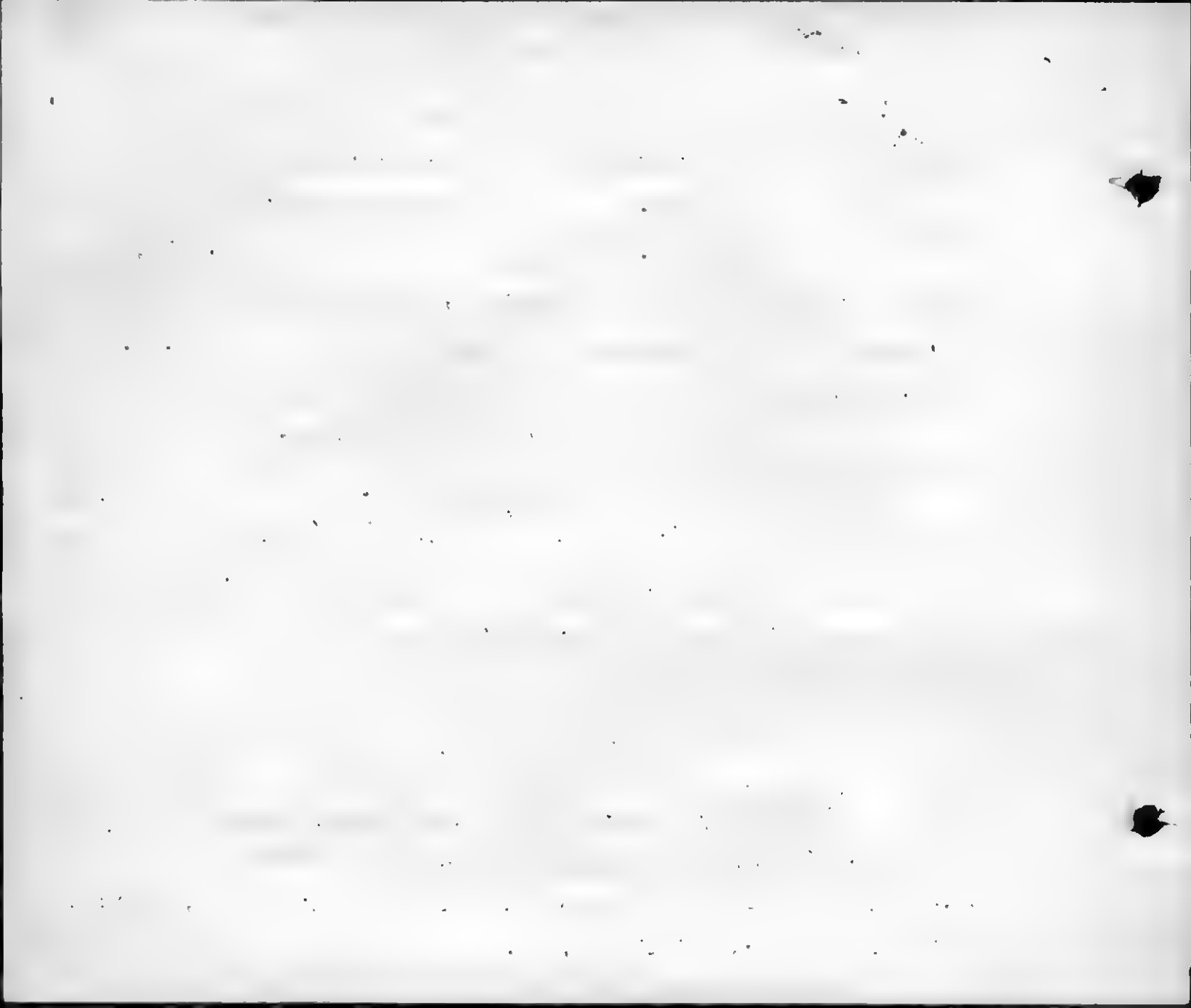
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15M 9/58

1 X  
9344 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09305

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Indiana</b> b. COUNTY <b>Marion</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8100 Beechtree Rd.</b>		d. STREET ADDRESS <b>1234 Prospect Street</b>	
3. NAME OF DECEASED (Type or print) First <b>LEORA</b> Middle <b>H.</b> Last <b>POLLEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1871</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR <b>3</b> Months <b>1</b> Days IF UNDER 24 HRS <b>1</b> Hours <b>1</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Mathew Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Bryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
INFORMANT <b>Daughter</b> <b>Nellie Polley Jackson</b>		Address <b>Same as Item#1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Constrictive heart failure</b> DUE TO (c) <b>Arterio Sclerotic Heart Disease</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRITIS, RHEUMATOID</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 yrs</b> <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/29</b> , 19 <b>59</b> to <b>8/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/12</b> , 19 <b>59</b> , and that death occurred at <b>5:15</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4090 Battery Lane</b> DATE SIGNED <b>8/17/59</b> ACTUAL SIGNATURE <b>Charles H. Salas</b> M.D. PHYSICIAN'S NAME (Type) <b>CHARLES SALAS</b> Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	22b. DATE THEREOF <b>8-13-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion County, Indiana</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>		ADDRESS <b>Bethesda, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



9232

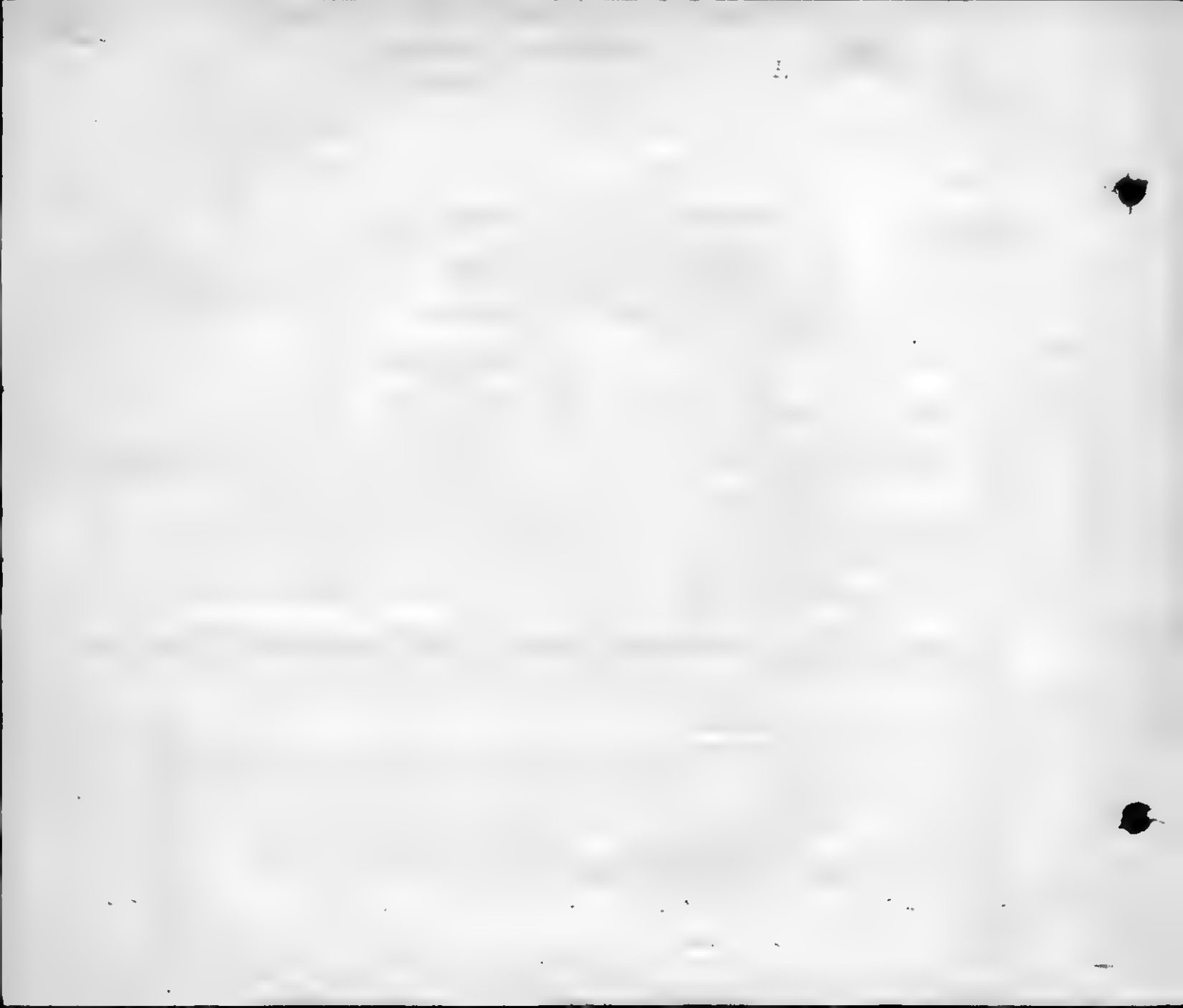
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN TB <u>3 mos</u>		d. STREET ADDRESS <u>Rte #4</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Tennessee</u> Last <u>Powers</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elihu Counts</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sutherland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lucille Bell</u>		Address <u>504 Fletcher Parkville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>59</u> , to <u>Aug 21</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 17</u> 19 <u>59</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman Chiofanzini</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd</u> DATE SIGNED <u>8/21/59</u>	
PHYSICIAN'S NAME (Type) <u>Herman Chiofanzini</u>		<u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug 23 '59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>RUSSELL MEMORIAL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>LEBANON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SAFFELL FUNERAL HOME - WESTMINSTER MD.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Tread</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9345

CERTIFICATE OF DEATH

Reg. Dist. No.

09307

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 2, Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 2, Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Susie</u> First <u>Valinda</u> Middle <u>Prather</u> Last		4. DATE OF DEATH <u>8</u> Month <u>1</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1884</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hess Washington</u>		14. MOTHER'S MAIDEN NAME <u>Valinda Disney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>HUSBAND</u> Address <u>Mr. William Prather RD 2, Gaithersburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility, Inanition</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 19, 1956</u> to <u>Aug. 1, 1959</u> , that I last saw the deceased alive on <u>July 31, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson</u>		DATE SIGNED <u>8-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert L. Suroder</u>		ADDRESS <u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>	22d. LOCATION (City town or county) (State) <u>Laytonsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suroder</u>		24a. REC'D BY REGISTRAR <u>AUG 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



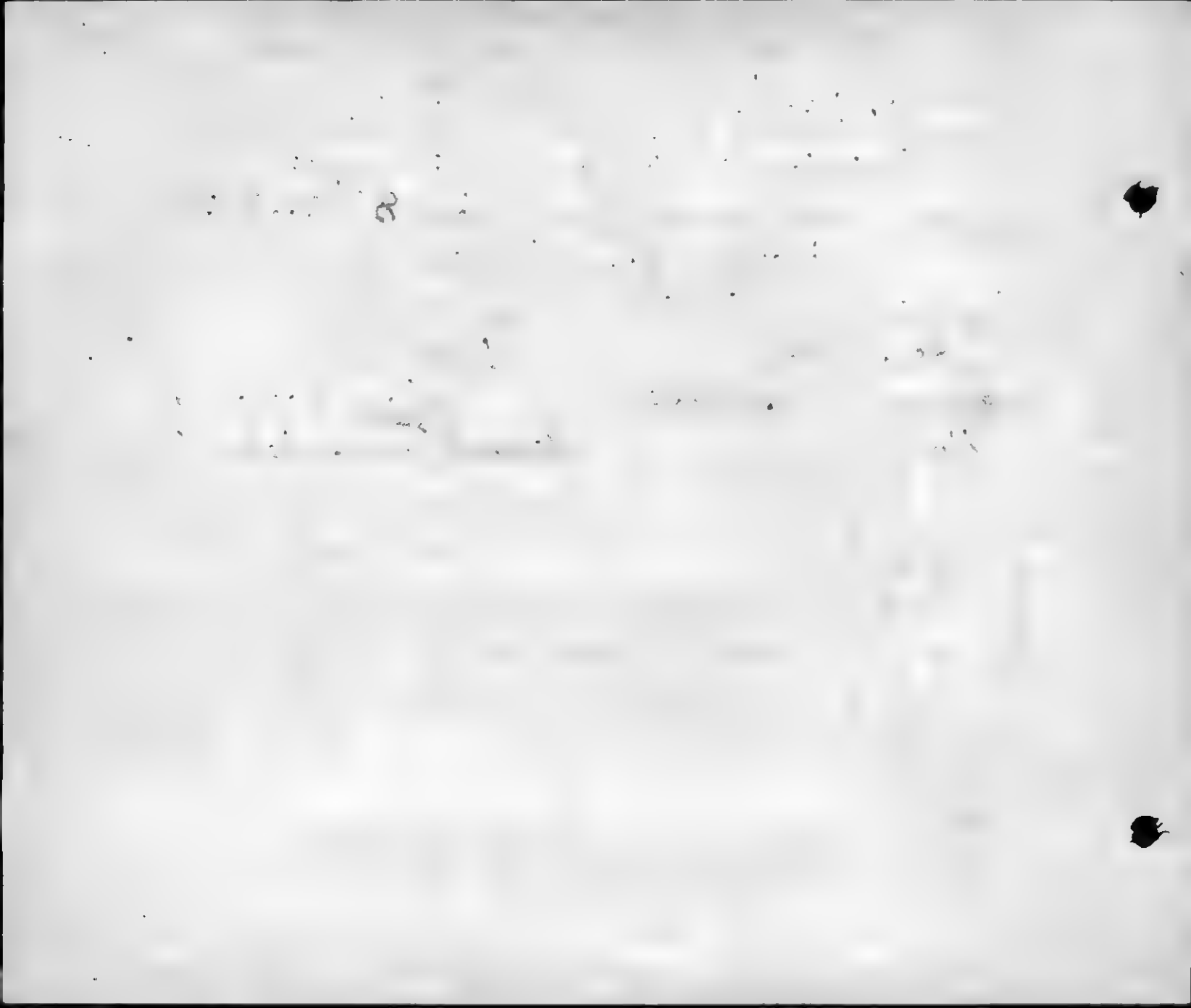
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9345 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09308

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 1 hr 10 mi c. LENGTH OF STAY IN lb. <u>1 hr 10 mi</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>621 8th Street N.E.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Price</u>				<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>10</u> Year <u>1959</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>C.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-2-1912</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____		<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Marion Timberlake</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Lula Roeland</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> _____				<b>17. INFORMANT</b> <u>Marshall Timberlake</u> (Address <u>608-7th St NW</u> )							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO _____ (c) <u>Coronary Artery Disease</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 1/2 hrs</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____									
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour _____ a. m. _____ p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>8-11-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>8-14-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Memorial</u>				<b>22d. LOCATION</b> (City, town, or county) _____ (State) <u>Md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William H. [unclear]</u>						<b>ADDRESS</b> <u>524-8th St N.E.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE: 8 14 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. [unclear]</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3316 Jones Bridge Rd</u>				d. STREET ADDRESS <u>3316 Jones Bridge Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Malcolm</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-1934</u>	
9. AGE (In years last birthday) <u>25 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas station</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas M. Price</u>				14. MOTHER'S MAIDEN NAME <u>Evangelina Betta Town</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Name <u>Heather Price (wife)</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage &amp; lacerations</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bullet wound in at skull</u> DUE TO (c) <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>shot self in at temple</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self in at temple</u>			
20c. TIME OF INJURY Month, Day, Year <u>11 a.m. 8-17 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Bensch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bensch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REINTERMENT <u>Cremation</u>		22b. DATE THEREOF <u>8/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kinn</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 1. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sisters of Mercy, Kendall Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Henry Reaves</b>		f. STREET ADDRESS <b>1508 14th St., N.W.</b>	
4. DATE OF DEATH <b>Aug. 3, 1959</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 7, 1918</b>	
9. AGE (in years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marshall Reaves</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louis Reaves</b>		Address <b>1637 11st., N.W. Wash. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			
DUE TO (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>8/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		22d. LOCATION (City, town, or county) (State) <b>Bullesboro Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>District Mortician</b>		24a. REC'D BY REGISTRAR <b>John D. Watson</b>	
ADDRESS <b>1700 Vermont Ave N.W.</b>		DATE <b>9-4-59</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

AUG 6 '59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10493

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>12104 Grandview Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>D</u> Last <u>Rees</u>			4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1933</u>	9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Lineman at Potomac Rural Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John David Rees</u>			14. MOTHER'S MAIDEN NAME <u>Frances Alberta Glotfelty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>577-12-8205</u>		
17. INFORMANT <u>Jean Rees</u> Address <u>Same</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Abnormally Enlarged</u> DUE TO <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Electric Shock</u> DUE TO <u>Electric Shock</u> (c) <u>Electric Shock</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from P.E.P. pole</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30</u> P.M. <u>8-12</u> 1959	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water Rd</u>	20f. (City or town) <u>Kensington Montg Ind</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Boeschant</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BOESCHANT</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-13-59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>ARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>			24a. REC'D BY REGISTRAR <u>DATE AUG 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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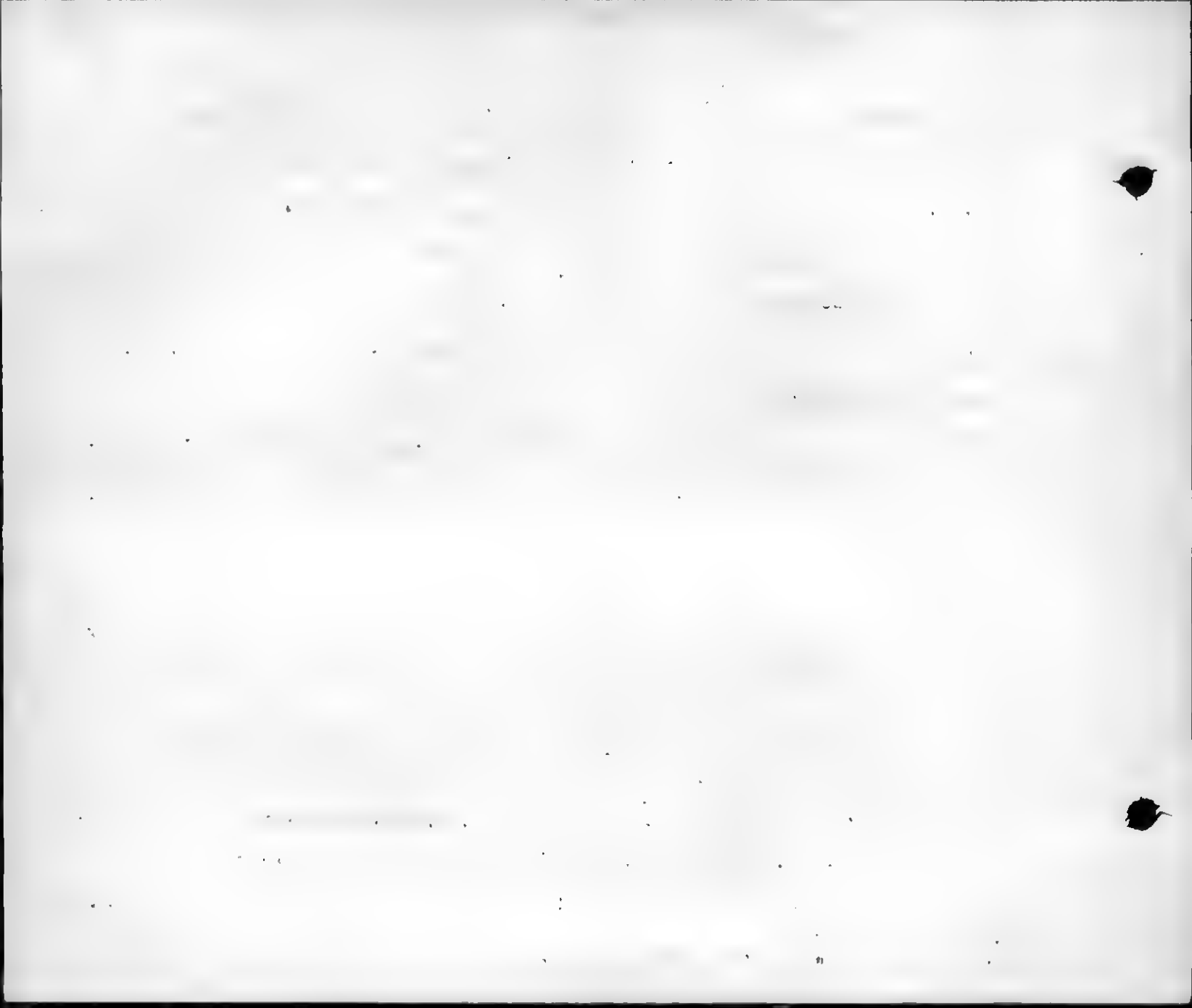
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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
9349														
CERTIFICATE OF DEATH														
Reg. Dist. No. 215														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>325 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5443 Alta Vista Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Terry REINICHE</b>					4. DATE OF DEATH Month Day Year <b>August 21 19 59</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-29-56</b>		9. AGE (In years last birthday) <b>2 yrs</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harvey Terry REINICHE</b>					14. MOTHER'S MAIDEN NAME <b>Lois LIVESAY</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					INFORMANT <b>(F) Harvey T. Reiniche, same as #2 above.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aplastic anemia</b> <b>72.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 30</b> , 19 <b>58</b> , to <b>August 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>7:55AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 8-21-59</b>														
ACTUAL SIGNATURE <b>Howard A. Pearson</b> M.D.					PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN Bethesda 14, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumbrey</b> ADDRESS <b>R.A. Pumbrey Funeral Home, Bethesda, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							





9350

## CERTIFICATE OF DEATH

Reg. Dist. No.

09313

1. PLACE OF DEATH o COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roberta</b> Middle <b>Jane</b> Last <b>Riley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/70</b>
9. AGE (In years lost birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>XXXXXX Henson Ricketts</b>		14. MOTHER'S MAIDEN NAME <b>Martha XXXXXXXXXX Carlisle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Roberta Bodman - daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE - 25 - 1959</b> to <b>AUG - 14 - 1959</b> , that I last saw the deceased alive on <b>AUG - 14 - 1959</b> and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>7 - Brooks Ave., Gaithersburg, Md</b>	
DATE SIGNED		DATE	
PHYSICIAN'S NAME (Type) <b>WILLIAM C. MILLER</b>		DATE <b>AUG 18 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/59</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Darnestown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Darnestown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pennington</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>AUG 18 1959</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.



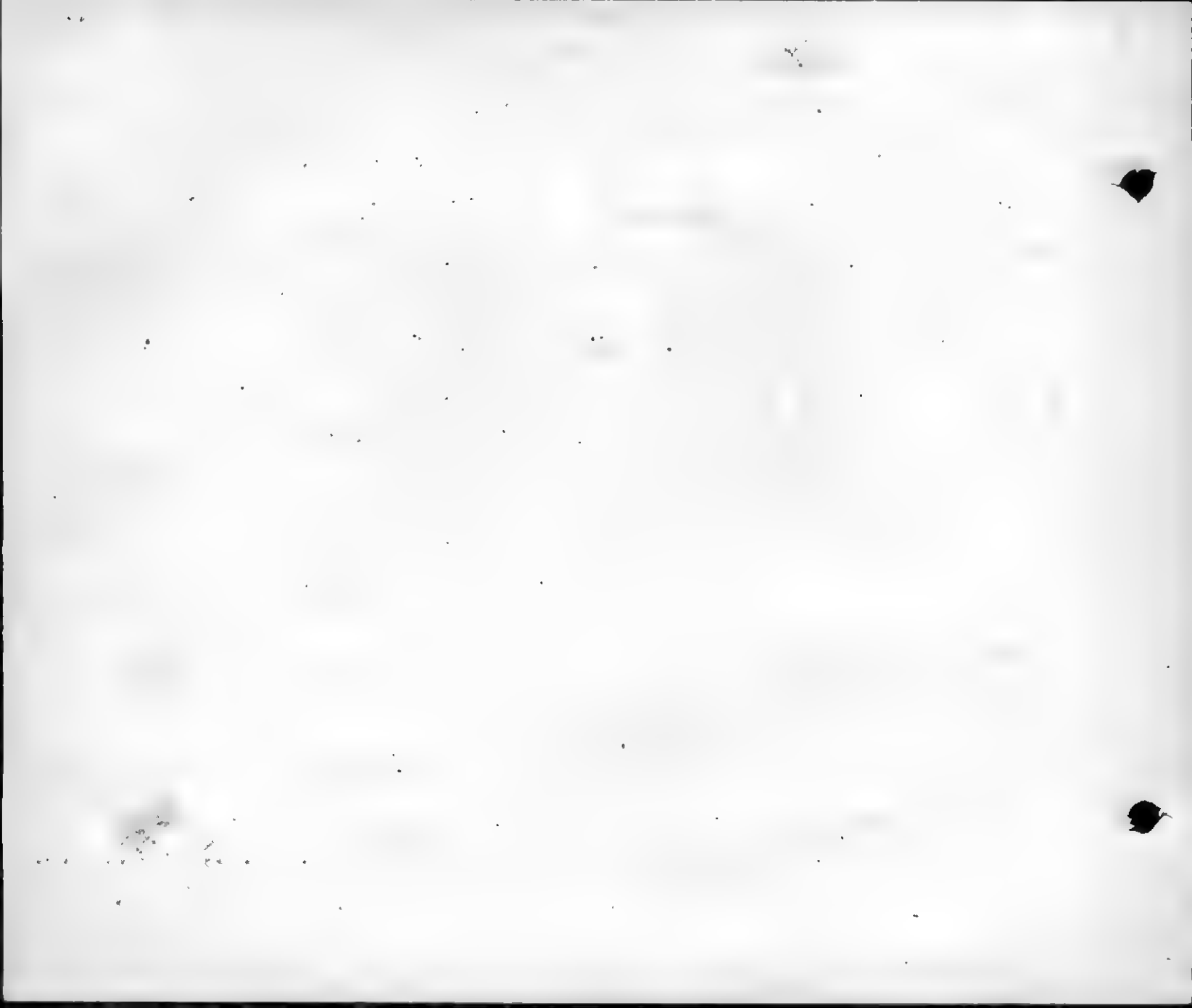
9233

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> <b>Stephen Rinker</b>		4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>1959</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/83</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MAIL MAN</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ALVIN RINKER</b>	
14. MOTHER'S MAIDEN NAME <b>ELLAMAND FRACK</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>INFORMANT</b>		Address <b>Sanitarium Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 22</b> , 19 <b>59</b> , to <b>Aug 28</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug 26</b> , 19 <b>59</b> , and that death occurred at <b>12:00 Noon</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Benjamin Isaacson</b> M.D. <b>7733 Alaska Ave. N.W. 8287</b> <b>Washington, D.C.</b> <b>7735 Alaska Ave., N.W., Wash., D.C.</b>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEMETERY</b>
22d. LOCATION (City, town, or county) <b>HAWERTOWN, PENNA.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Garbison</b>		24a. REC'D BY REGISTRAR <b>1756 Pa. Ave. N.W. Wash. D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law. The funeral director is responsible for the completion of the certificate. The registrar is responsible for the completion of the certificate. The registrar is responsible for the completion of the certificate.

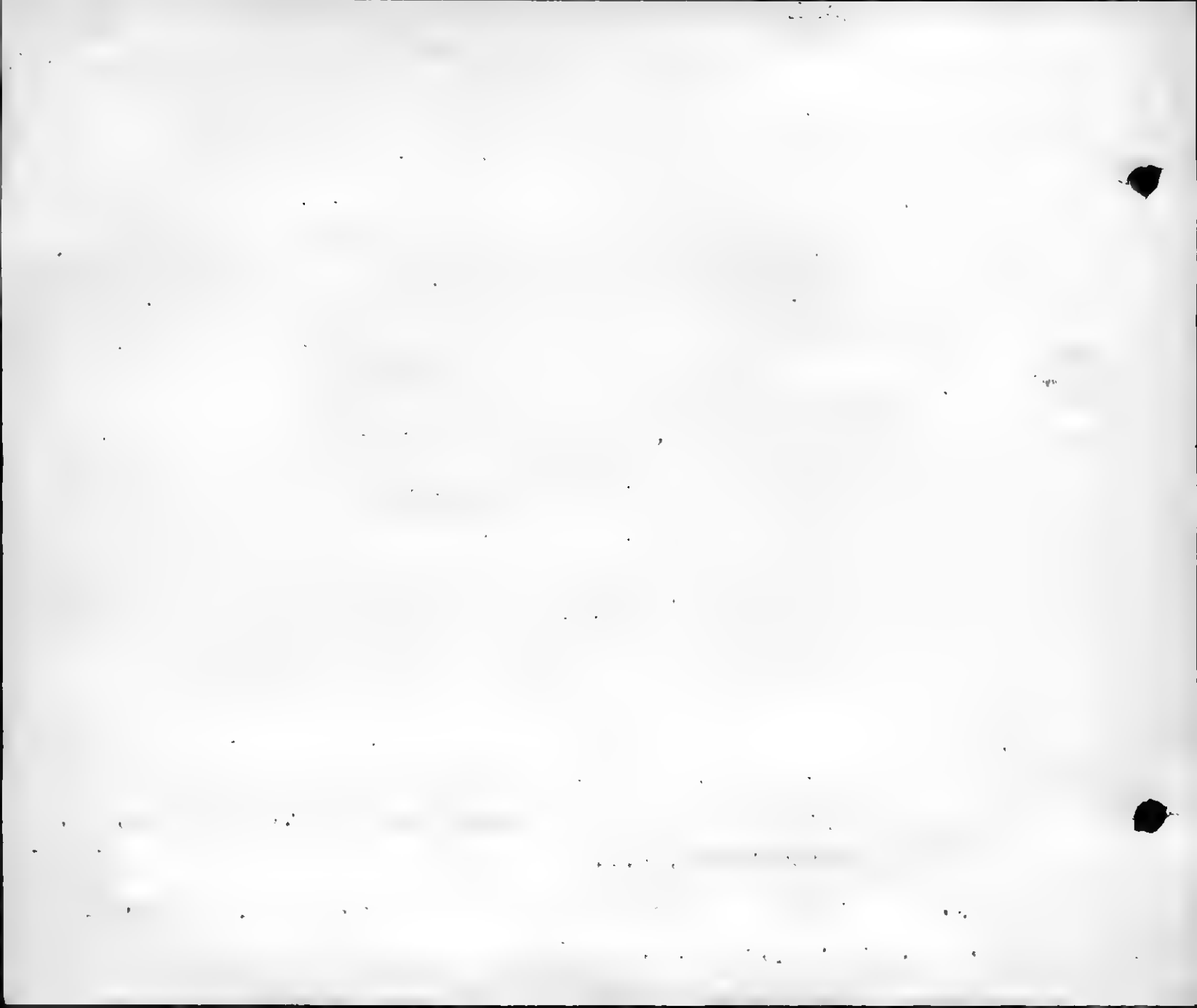


9351 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

09315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> c. LENGTH OF STAY IN lb <i>28 DAYS</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN HOSPITAL</i>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>PENNSYLVANIA</i> b. COUNTY <i>JOHNSTOWN</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>JOHNSTOWN</i> d. STREET ADDRESS <i>R.D. #13 BOX 179</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Nabel</i> Middle <i>A</i> Last <i>ROSE</i> 4. DATE OF DEATH Month <i>8</i> Day <i>5</i> Year <i>1959</i>		5. SEX <i>FEMALE</i> 6. COLOR OR RACE <i>WHITE</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>11/13/92</i> 9. AGE (In years last birthday) <i>66</i> yrs. IF UNDER 1 YEAR Months <i>8</i> Days <i>22</i> IF UNDER 24 HRS. Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaking</i> 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JOHN TAYLOR PECKMAN</i> 14. MOTHER'S MAIDEN NAME <i>EDNA FREDRESY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>Unknown</i> 17. ADDRESS <i>EDWARD ROSE (HUSBAND) S.M.C.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Cerebral Thrombosis</i> DUE TO (b) <i>Arterio-sclerosis</i> DUE TO (c) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> 19 <i>59</i> to <i>8/5</i> 19 <i>59</i> that I last saw the deceased alive on <i>8/5</i> 19 <i>59</i> and that death occurred at <i>1:35</i> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Charles Farwell</i> <i>12126 Viers Mill Rd. Silver Spring, Md.</i> <i>8/5/1959</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>8/8/59</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Richland</i> 22d. LOCATION (City, town, or county) (State) <i>Cambria Co. Pennsylvania</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i> 24a. REC'D BY REGISTRAR DATE <i>AUG 7 '59</i> 24b. REGISTRAR'S SIGNATURE <i>William E. Frank</i>	



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9352

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09316

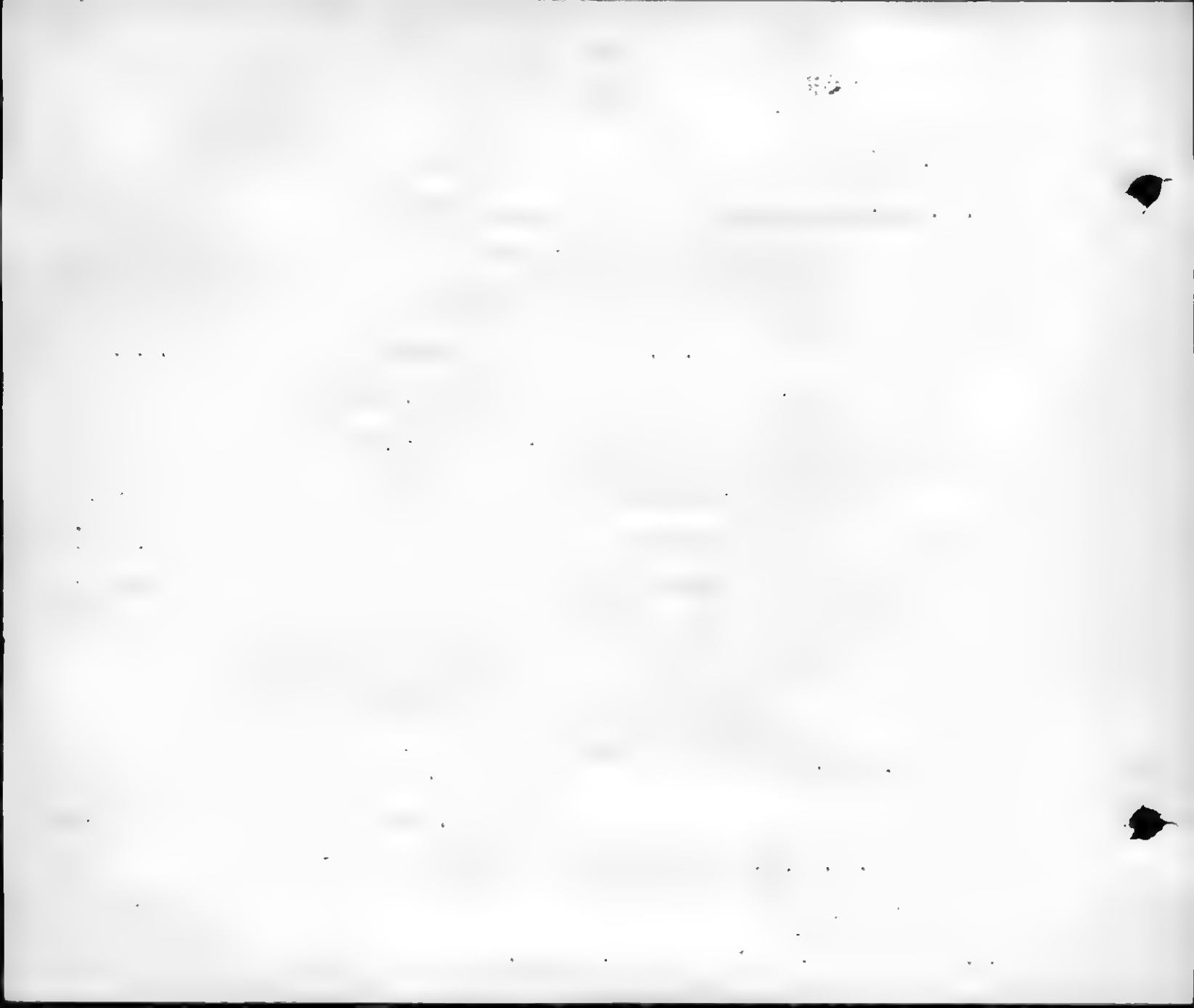
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montgomery</b> d. STREET ADDRESS <b>1426 Good Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Theodore Roosevelt ROWELL</b>				4. DATE Month Day Year <b>August 20 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-10-18</b>	
9. AGE (In years last birthday) <b>40 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>John Wesley ROWELL</b>				14. MOTHER'S MAIDEN NAME <b>Jessie D. COGBORN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1941 to DOD</b>				16. SOCIAL SECURITY NO. <b>419-18-8482</b>		INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hepatoma</b> DUE TO (c) <b>Cirrhosis, liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 mos (appr)</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 2</b> , 19 <b>59</b> , to <b>August 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 19</b> , 19 <b>59</b> , and that death occurred at <b>2:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 8-20-59</b>							
ACTUAL SIGNATURE <b>B. H. Rice</b>				M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>B. H. RICE, LT, MC, USN</b>				<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>8-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. J. K.</b>				ADDRESS <b>W.W.Chambers &amp; Co., 1400 Chapin St.NW, Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





9353

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

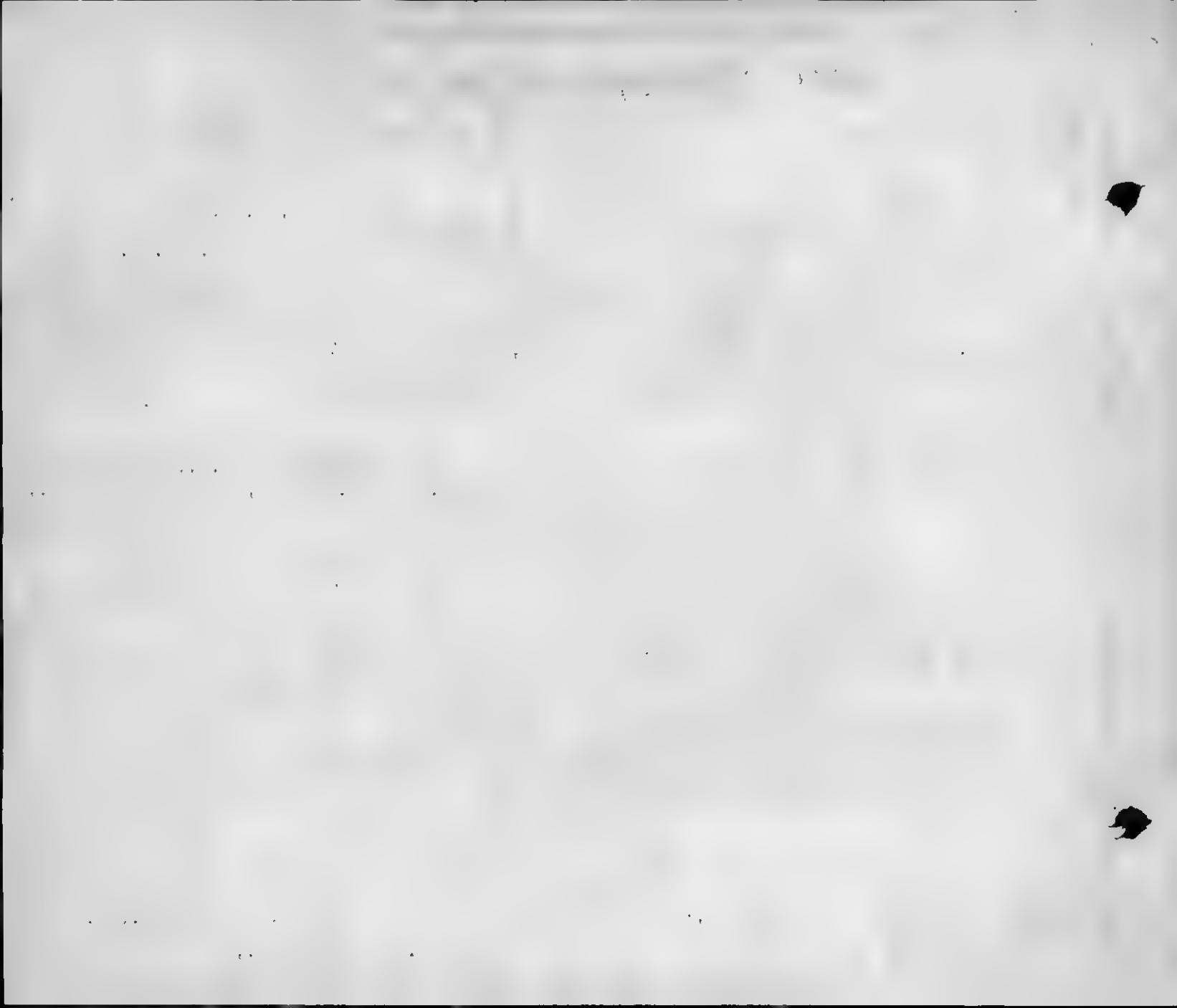
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u>		STATE <u>MARYLAND</u>		COUNTY		STATE	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SANDY SPRING</u>		LENGTH OF STAY (In this place) <u>9 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SHARON NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>1644 MICHIGAN AVE., N. E.</u>			
3. NAME OF DECEASED (Type or Print) <u>ELVINA CLARISSA RUMBAUGH</u>				4. DATE OF DEATH (Month) <u>AUGUST</u> (Day) <u>12</u> (Year) <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 1, 1882</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker (retd)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>JACOB OBEDIAH BECK</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET NOLF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>(N.E., WASHINGTON, DC)</u> <u>MRS. FRED L. THOMAS, 1644 MICHIGAN AVE.,</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Right Hemiplegia</u>						<u>30 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/7</u> , 19 <u>59</u> , to <u>8/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>59</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>[Signature]</u>		DATE SIGNED <u>8/12/59</u>	
III. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>AUGUST 15, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		LOCATION (city, town, or county) (State) <u>BETHEL, CRAWFORD CO., PA.</u>	
24. REC'D BY REGISTRAR DATE <u>AUG 14 '59</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u> <u>[Signature]</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09318

9222

## CERTIFICATE OF DEATH

Reg. Dist. No.

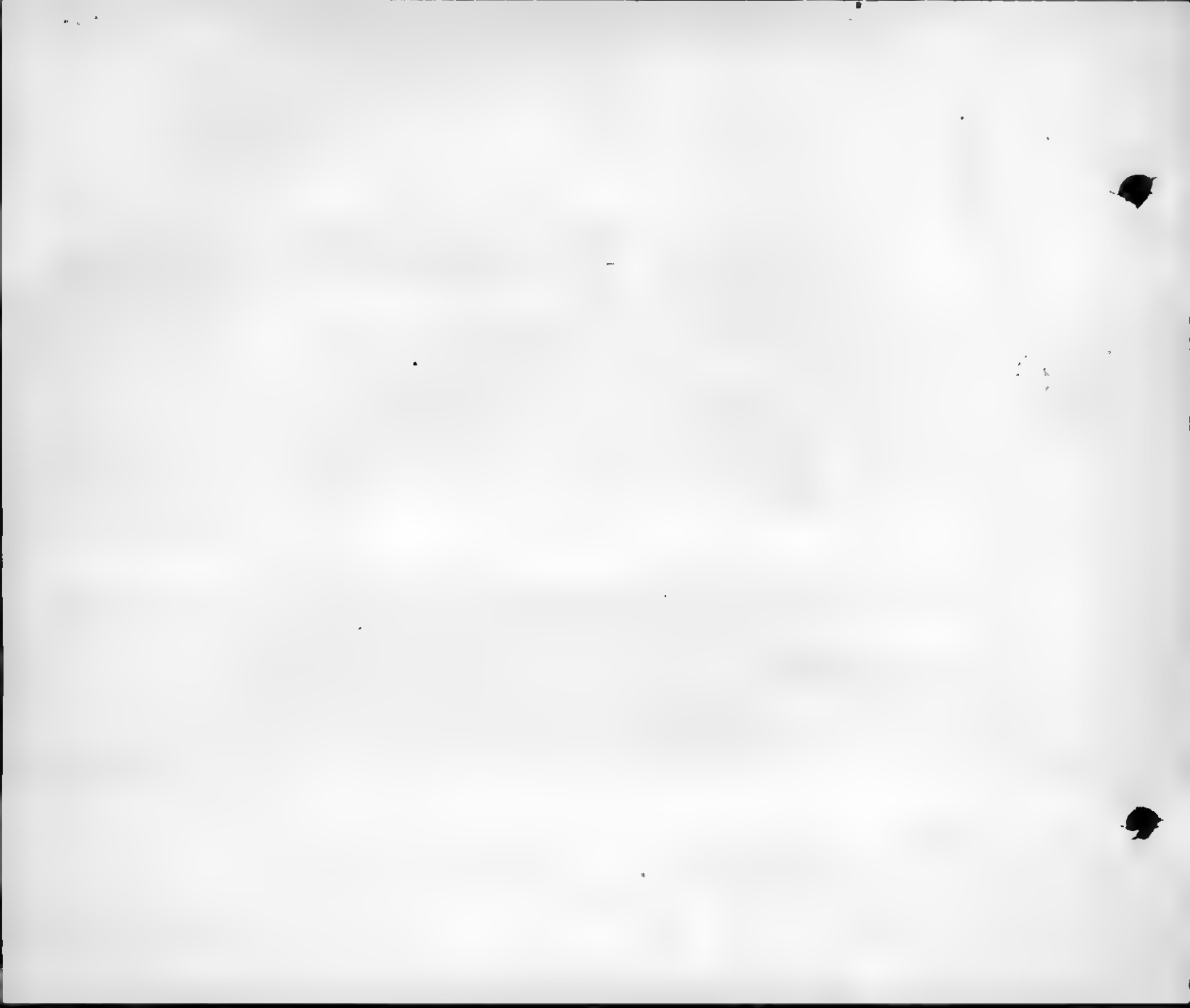
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Burtonsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Margherita (NMA) Santini</u>		4. DATE OF DEATH <u>August 9 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>John Maschio</u>		14. MOTHER'S MAIDEN NAME <u>Maria</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - senility</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1959</u> to <u>Aug 9, 1959</u> , that I last saw the deceased alive on <u>Aug 8, 1959</u> , and that death occurred at <u>1:05 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D. <u>918 Ellsworth Drive</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		<u>Summer Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CATHOLIC CEMETERY</u>	22d. LOCATION (City, town or county) (State) <u>LAUREL PROTD CO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hall</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 1959</u>	
ADDRESS <u>WASH 12, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



09319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKEVILLE</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SAM</b>		First <b>SAM</b>		Middle <b>--</b>		Last <b>SARGENT</b>		4. DATE OF DEATH Month <b>AUGUST</b>		Day <b>5</b>		Year <b>19 59</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/11/89</b>		9. AGE (In years last birthday) yrs <b>70</b>		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>		Hours <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CHARLES HENRY SARGENT</b>		14. MOTHER'S MAIDEN NAME <b>LUCY ELLEN COOCH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>					
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Nephrosclerosis</b>		19. WAS ALTPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>59</b> , to <b>May 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 5</b> , 19 <b>59</b> , and that death occurred at <b>1:28 A.M.</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>Clarksville, Md.</b>		DATE SIGNED <b>5-5-59</b>		ACTUAL SIGNATURE <b>Charles S. Whitaker</b>					
PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>		CLARKSVILLE, MARYLAND		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>8-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Hummers, Annapolis, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Wright</b>		ADDRESS <b>Clarksville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Whitaker</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

9355

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Filed 9-29-59 et

Reg. Dist. No.

09320

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5710 Aberdeen Road</b>				d. STREET ADDRESS <b>5710 Aberdeen Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>A.</b> Last <b>Sayre</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>13,</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1907 Feb. 14, 1906</b>	
9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Econ. Statistician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur Sayre</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Edmund Neary - Friend</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c) <b></b> (a), stating the underlying cause last. DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>				22b. DATE THEREOF <b>8-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>E. Ridgellawn Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Delawanna, New Jersey</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda 14, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

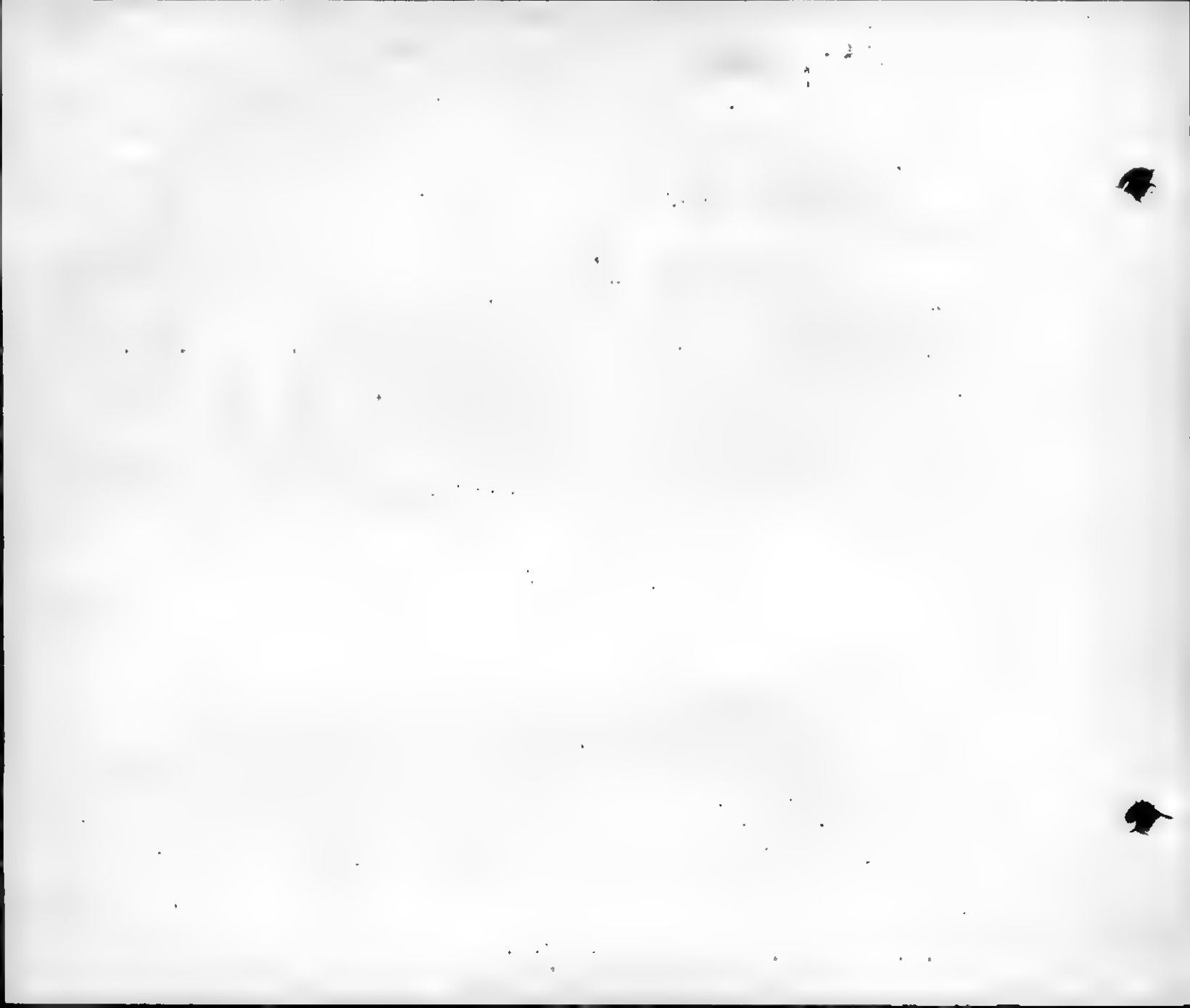
09321

9223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>700 Hudson Avenue EVENTIDE NURSING HOME</b>		d. STREET ADDRESS <b>6606 23rd Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>E.</b> Last <b>SCHLERF</b>		4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/1873</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b> Hours <b>15</b> Min <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filing Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthew Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Martha J. Beall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Records at Nursing Home</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>senility</b> DUE TO (c) <b>Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1957</b> , 19 to <b>Aug 12</b> , 1959 (that I last saw the deceased alive on <b>Aug 11</b> , 1959, and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. W. Smith</b>		ADDRESS (Street, city or town, state) <b>1821 RANDOLPH ST. NW</b>	
PHYSICIAN'S NAME (Type) <b>A. W. SMITH</b>		DATE SIGNED <b>8/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.</b>		24a. REC'D BY REGISTRAR <b>AUG 13 '59</b>	
ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9356

CERTIFICATE OF DEATH

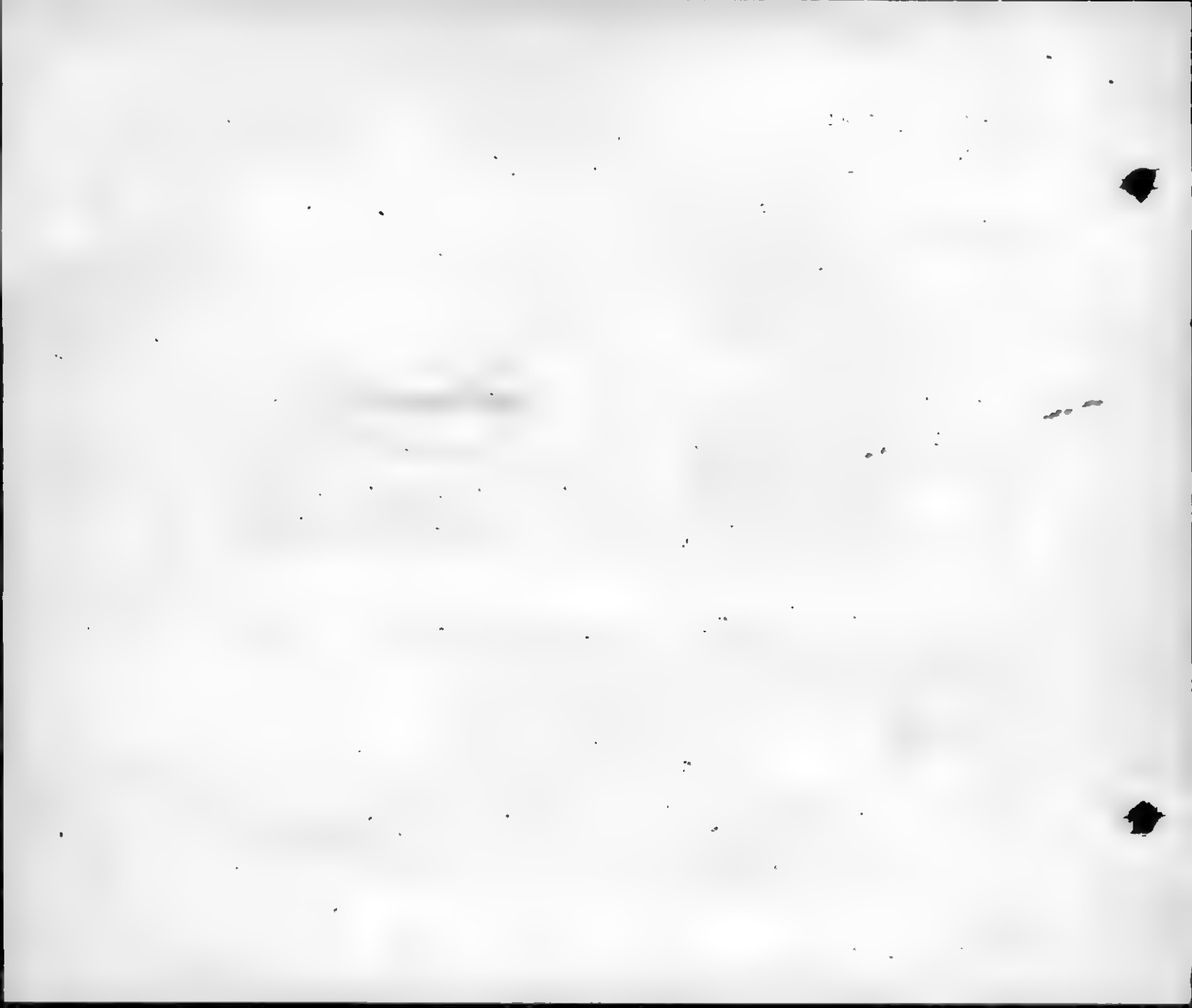
09322

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>1493 Hampton Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harvey</u> First <u>Broder</u> Middle <u>Schwartz</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31</u>		9. AGE (In years, lost birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Express Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Joseph Schwartz</u>			
14. MOTHER'S MAIDEN NAME <u>Mollie Musgrove</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>74-01-21400-8</u>				17. INFORMANT <u>W.C.D. Murphy &amp; Son, 4803 Hampton Lane</u> Address <u>Bethesda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>420.1</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> (c) <u>left ventricular hypertrophy</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> (b) <u>left ventricular hypertrophy</u> (c) <u>left ventricular dilatation</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>59</u> , to <u>8/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert U. Coale</u>				ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda, Md.</u>		DATE SIGNED <u>8/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert U. Coale</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manassas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manassas, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2

MEDICAL CERTIFICATION



9357

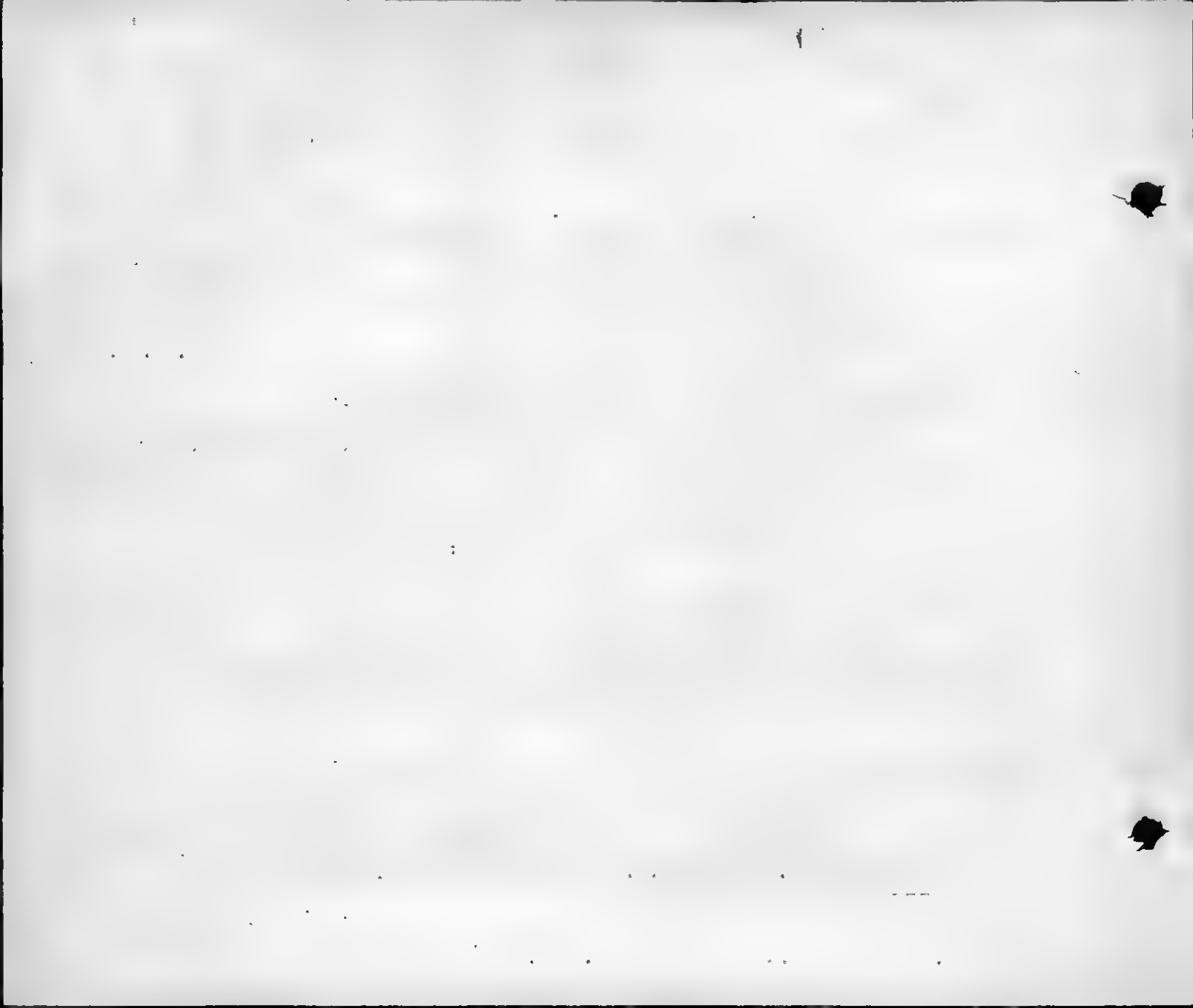
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Colorado</b> b. COUNTY <b>Trinidad</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>32 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1708 San Pedro Street</b>			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Ann</b> Last <b>Sciaccia</b>				4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1944</b>	
9. AGE (In years last birthday) <b>15</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Lawrence Sciaccia</b>				14. MOTHER'S MAIDEN NAME <b>Sarafena Antista</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized hemorrhages</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia; severe pancytopenia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>59</b> , to <b>August 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 2</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>8/3/59</b>							
ACTUAL SIGNATURE <b>L. A. Gaydos</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M.D.</b>				<b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL OR CREMATION REMOVAL (Specify) <b>removal</b>				22b. DATE THEREOF <b>8/3/59</b>			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) <b>Trinidad, Colorado</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. Wash, D.C. N.W.</b>				24a. REC'D BY REGISTRAR <b>AUG 4 1959</b>			
24b. REGISTRAR'S SIGNATURE <b>Edmund S. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9224

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sen. and Hosp.</u>		d. STREET ADDRESS <u>1707 Rosmere Ave. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Joseph</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-45</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Lewis &amp; Joseph Scott</u>		14. MOTHER'S MAIDEN NAME <u>Clara Mae Musketman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Lewis Scott, Father</u>		Address <u>707 Rosmere Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>drowning</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> Min. <u>  </u> P. M. <u>8-10</u> 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <u>N.W. Branch</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Silver Spring</u>		20f. (City or town) (County) (State) <u>Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-10-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10477

9358

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		STATE <u>md</u>		COUNTY <u>Annamiddle</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn, md.</u>			
TOWN <u>Silver Spring</u>				STREET ADDRESS (If rural give location) <u>14511 Colesville Rd. Silver Spring, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marilee Nursing Home 14511 Colesville Rd.</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Reuben</u> (First) <u>Shiftlett</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Aug. 14</u> (Day) (Year) <u>1959</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <u>Oct 27-1887</u>	<b>9. AGE last birthday</b> <u>73</u> yrs.	<b>10. UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Jack Shiftlett - HARVEY Ave Severn Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.1 IMMEDIATE CAUSE</b> (A) <u>of atherosclerosis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 wk.</u>			
<b>ANTECEDENT CAUSE(S)</b> (B) <u>Chronic cardiovascular disease</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <u>Generalized arteriosclerosis</u>							
<b>STATING UNDERLYING CAUSE LAST.</b> <u>None</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>None</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 11, 1957, to Aug 14, 1959, that I last saw the deceased alive on Aug 10, 1959, and that death occurred at 10 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John V. Cohen</u> M.D.				<b>DATE SIGNED</b> <u>8-14-59</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremated</u>		<b>DATE THEREOF</b> <u>9-8-59</u>		<b>NAME OF CEMETERY OR CREMATOR</b> <u>St. Ignace Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur G. Kraus</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <u>SEP 10 '59</u>							



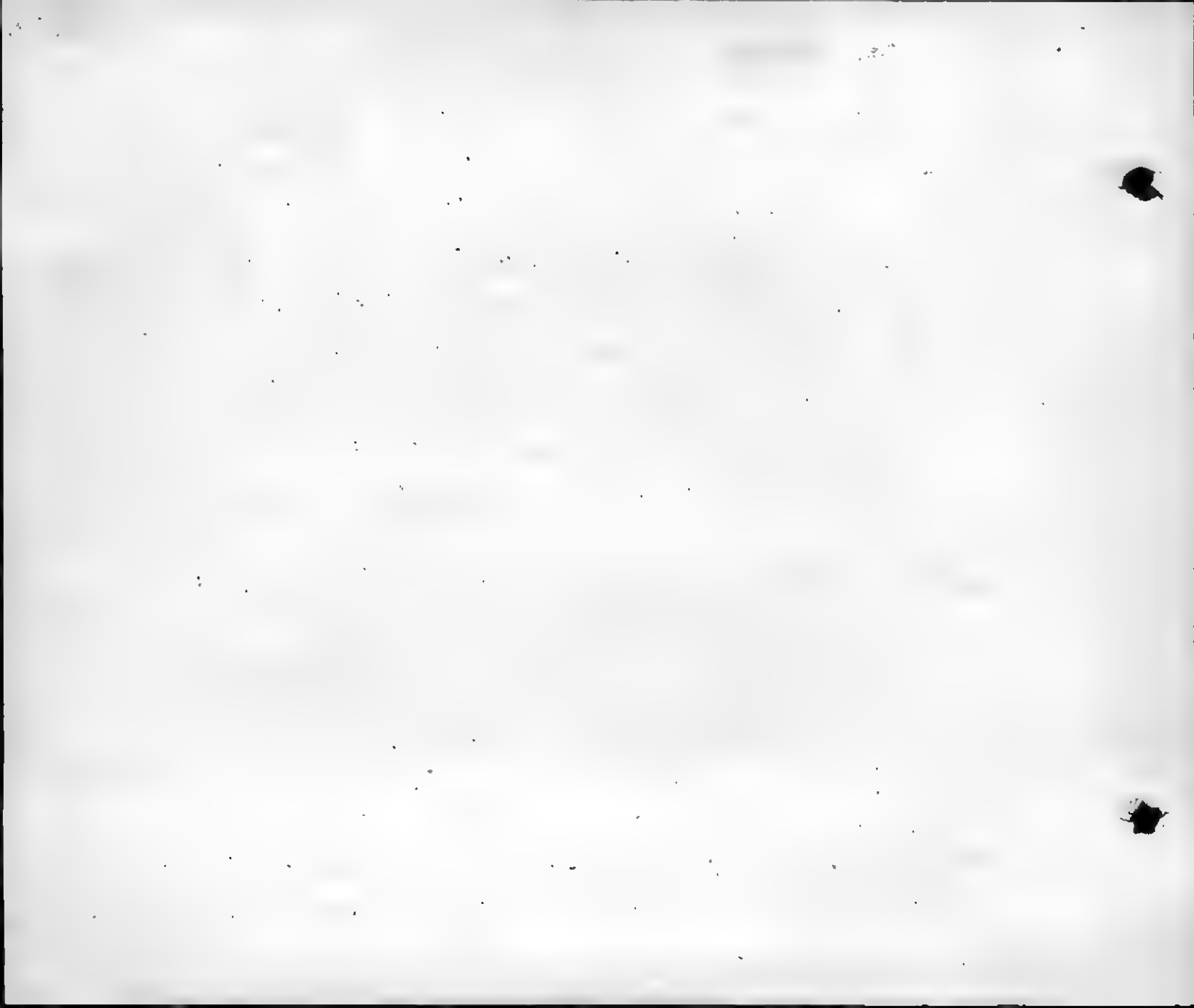
9225

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>56 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Allen Smart</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. John G. Smart</u>		14. MOTHER'S MAIDEN NAME <u>Leleka Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon and</u> <u>153.8</u> DUE TO <u>Bowel obstruction</u> Conditions, if any, which gave rise to immediate cause (a); stating the <u>underlying</u> cause last (c) <u>Generalized Metastatic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 mos, 6 weeks</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec.</u> , 1958, to <u>Aug.</u> , 1959 that I last saw the deceased alive on <u>8/16</u> , 1959, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Braunsberger M.D.</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u>	
PHYSICIAN'S NAME (Type) <u>John F. Braunsberger</u>		DATE SIGNED <u>Paloma Park Md.</u>	
22a. BURIAL, CREMATION, or REBURYAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLANDS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE, NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Gowler's Sons</u>		24a. REC'D BY REGISTRAR <u>AP</u> DATE <u>AUG 19 '59</u>	
ADDRESS <u>1752 Pa. Ave. NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9359**  
**CERTIFICATE OF DEATH**

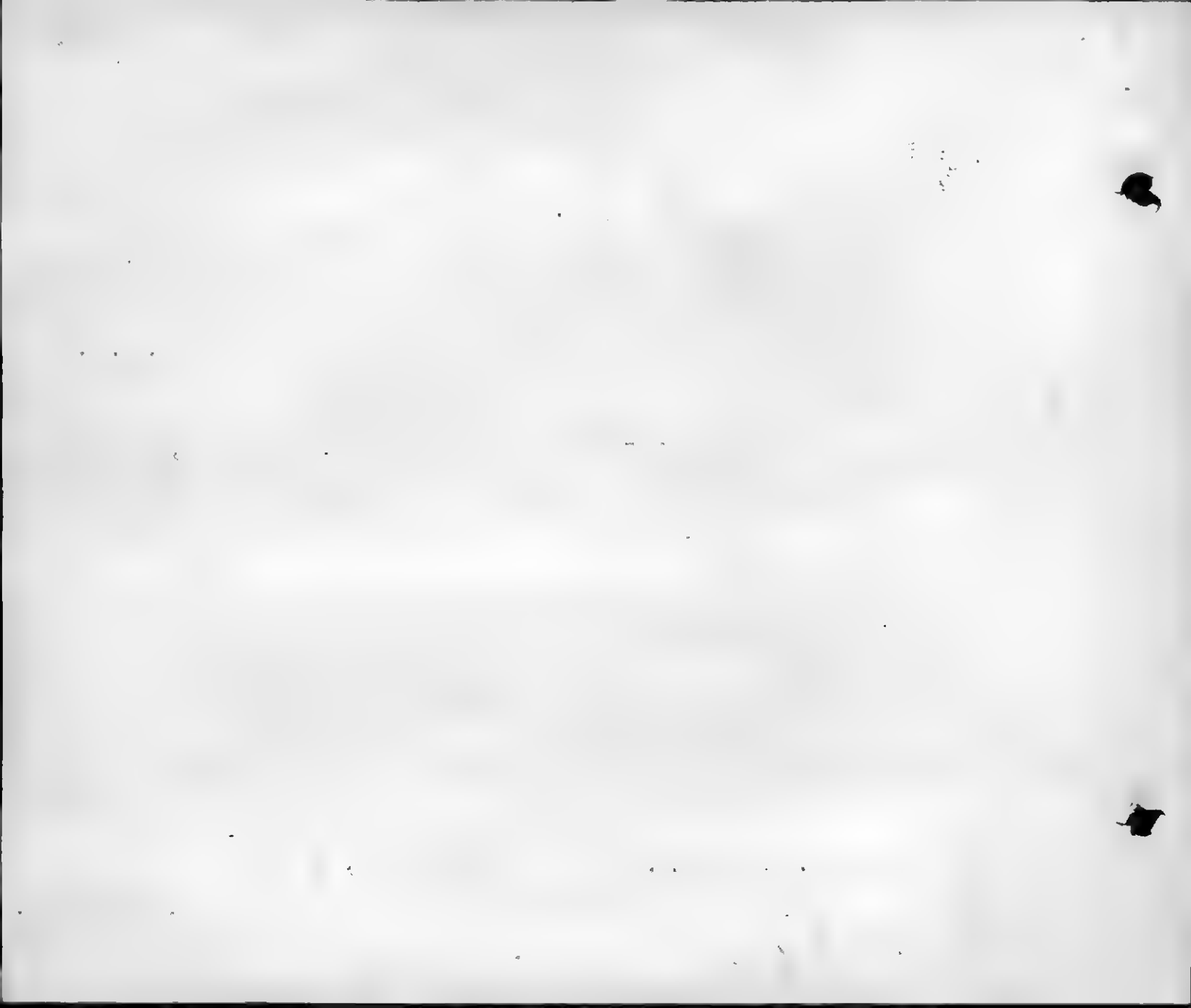
09326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>94 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Los Angeles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Covina, 401-E</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>4954 Vecino Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Monica</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1916</b>
9. AGE (In years last birthday) <b>43</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b>10</b> Min <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Croak</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>396-18-5283</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Upper Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>1 Year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Hemothorax</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>August 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 28</b> , 19 <b>59</b> , and that death occurred at <b>10:19p</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/29/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE <b>Jerry S. Triet</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JERRY S. TRIET, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 8-30-59</b>		22b. DATE THEREOF <b>8-30-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Little Wolf Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waupaca County, Wisconsin.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Humphrey</b> ADDRESS <b>BETHESDA, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 1 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

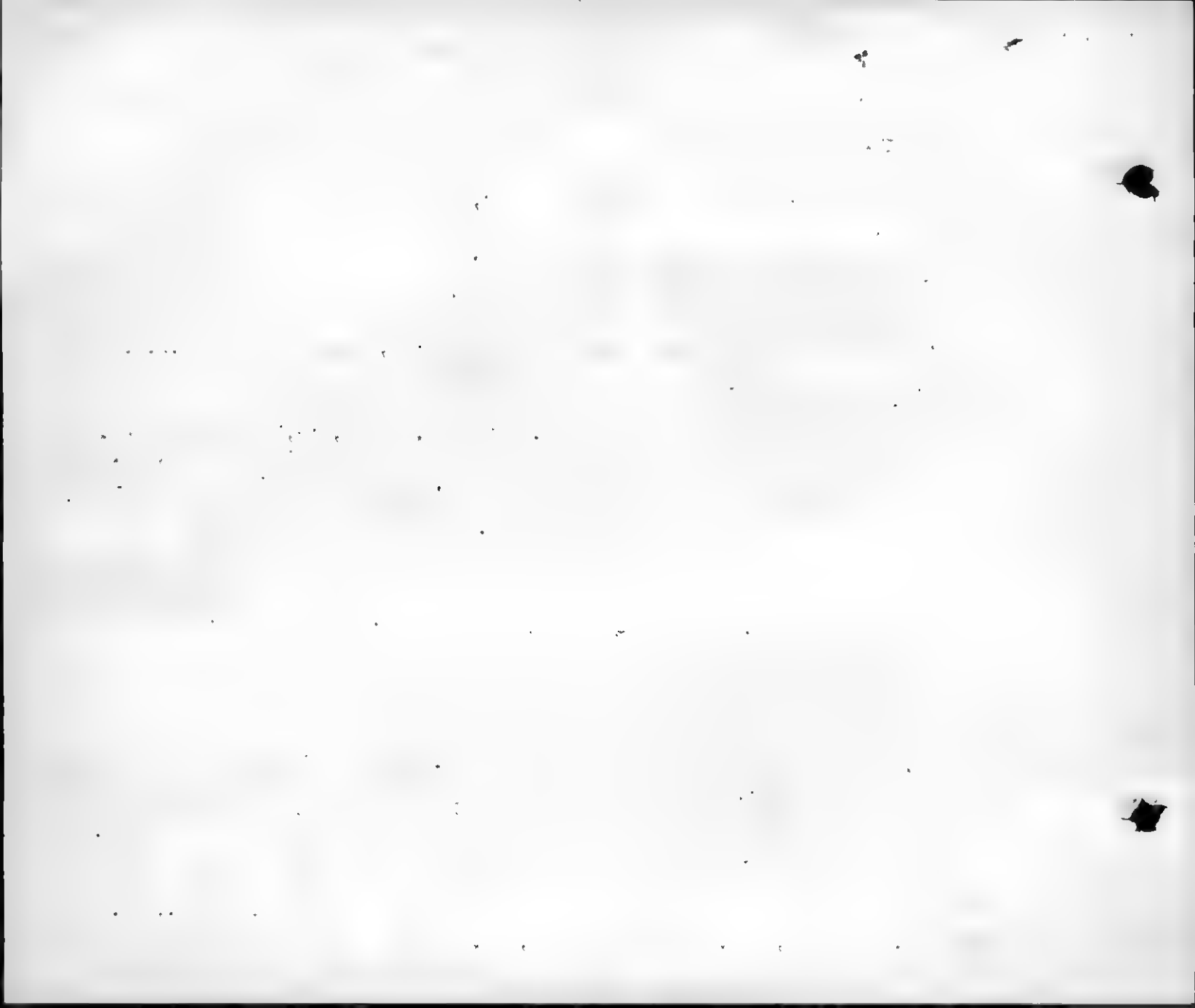
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9360 CERTIFICATE OF DEATH

Reg. Dist. No.

09327

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>10,121 KINROSS AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>M.</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/87</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b>4</b> Min. <b>40</b>	IF UNDER 24 HRS Hours <b>2</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Alexandria, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM ELLIS</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA SKILLMAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mr. Norman S. Smith, 10,121 Kinross Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>4-42 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage (1 month)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>June 59</b> to <b>29 Aug 59</b> that I last saw the deceased alive on <b>28 Aug 59</b> and that death occurred at <b>9:59 PM</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>4006 Calverville Rd Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9361

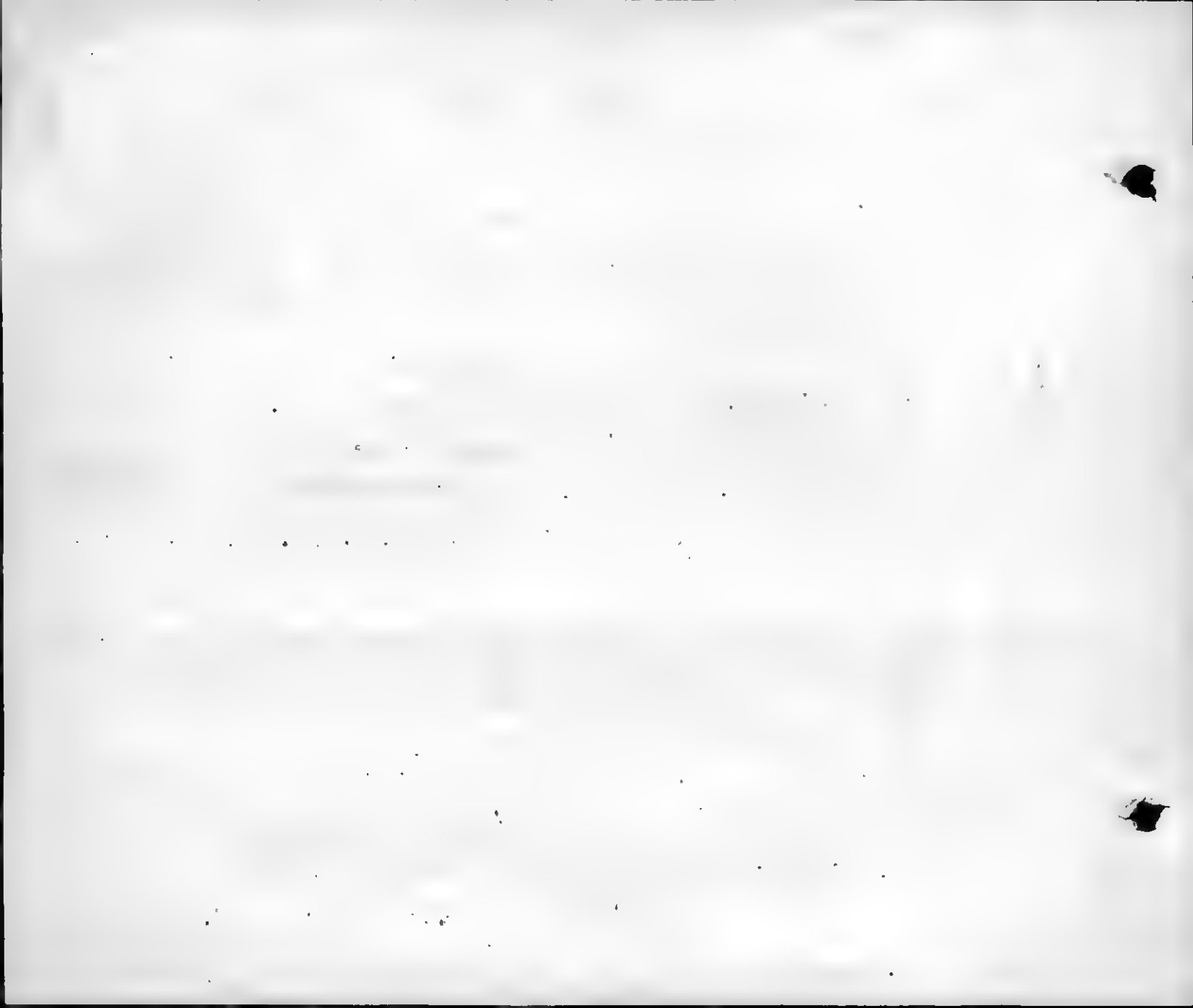
Item 9 Film G246 8-18-59 et

## CERTIFICATE OF DEATH

09328

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>506 Crabb Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Elizabeth</u> Middle <u>May</u> Last <u>T. Snell</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/12</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Herndon, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frank C. Samsell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bowie Oliver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-20-1853</u>		INFORMANT <u>Husband (Same As Above)</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine Hemorrhage</u> DUE TO <u>330x</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Ruptured Aneurysm, left Anterior communicating</u> DUE TO <u>5 days</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 5, 1959</u> to <u>Aug. 10, 1959</u> , that I last saw the deceased alive on <u>Aug. 7, 1959</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Bowditch Hunter, M.D.</u>				ADDRESS (Street, city or town, state) <u>506 Crabb Ave. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. Bowditch Hunter</u>				DATE SIGNED <u>8/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>5801 Cleveland Ave. Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 12 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



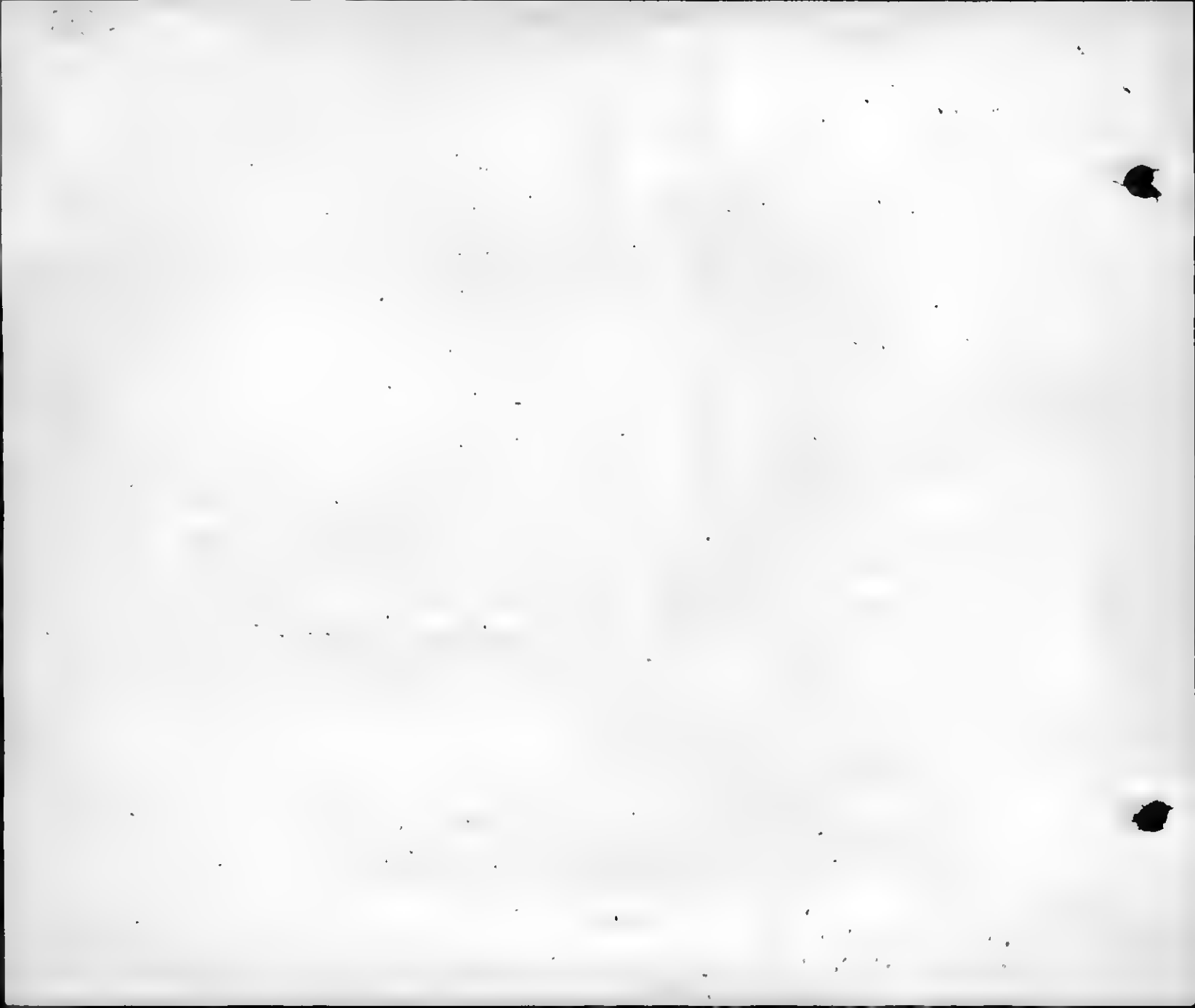
9362

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON - D.C. 4</u>			
c. LENGTH OF STAY IN 1b <u>27 DAYS</u>				d. STREET ADDRESS <u>3708 BEAUFORT ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>MONROE</u> Last <u>SPENCER</u>			4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1959</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-30-1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OMER R. SPENCER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZ. BEZNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1917-1920</u>		INFORMANT <u>CHARLOTTE E. SPENCER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, severe</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular-renal arteriosclerosis</u> DUE TO (c) <u>Hypertension, severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>5 yrs +</u> <u>5 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Old left &amp; recent right hemiplegia 2) Nephrosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> to <u>Aug 17, 1959</u> , that I last saw the deceased alive on <u>Aug 16, 1959</u> , and that death occurred at <u>1245</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St</u>				<u>8/17/59</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Washington 15 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Curtis S. Hanna</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be examined within 24 hours of death. Page 4 may be retained by the hospital or funeral home. The law requires that the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9363

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09330

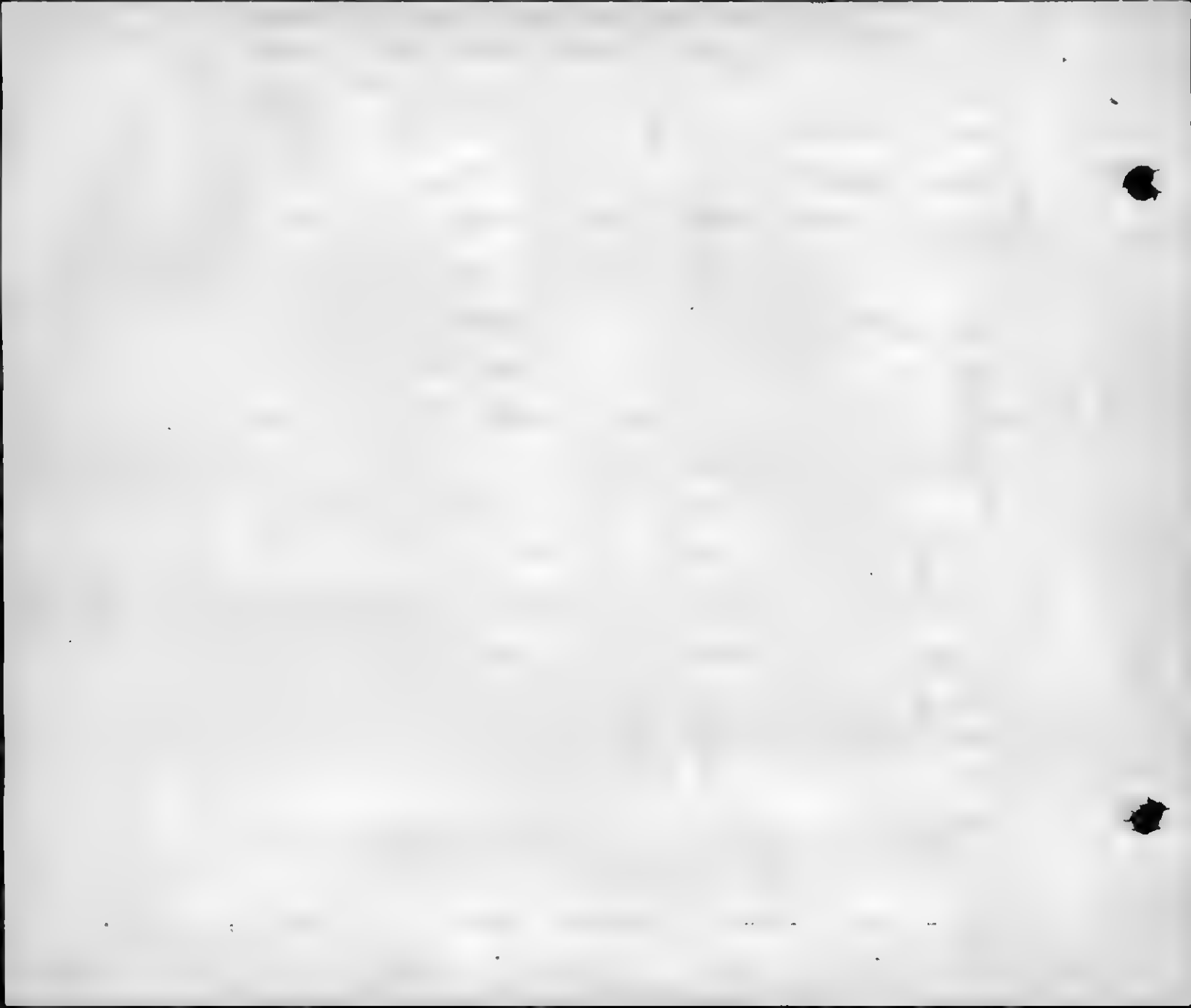
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9815 Hawthill Drive</u>				d. STREET ADDRESS <u>9815 Hawthill Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Sherling</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1873</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Springer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Overby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Jane Warrick</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blischak</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BLISCHAK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		8-21-59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-transit 8-23-59</u>				<u>Woodlawn Cemetery</u>		<u>Wilkinsburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carl S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9364

## CERTIFICATE OF DEATH

09331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 WHITESTONE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>MARY</b> Last <b>STICKLER</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/69</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>20</b> Hours <b>22</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB STICKLER</b>		14. MOTHER'S MAIDEN NAME <b>AGATHA ROTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>yes</b>	
17. INFORMANT <b>Mrs. Marie A. Preller, 206 Whitestone Road Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1, 1959</b> to <b>Aug 9, 1959</b> , that I last saw the deceased alive on <b>Aug 9, 1959</b> , and that death occurred at <b>6:30</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Winkler, Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>JOHN W. WINKLER, JR.</b>		M.D. <b>5500 10th St. Silver Spring, Md. 20910</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SILVER SPRING, MD.</b> DATE <b>AUG 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9226

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>9 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6903 Laurel Ave</u>		e. STREET ADDRESS <u>515 Decatur St N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>William Henry Stith</u>		4. DATE OF DEATH <u>Aug 10 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 1909</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>store</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Stith</u>		14. MOTHER'S MAIDEN NAME <u>Etta Blunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>225-36-0289</u>	
17. INFORMANT <u>John H. Pettit - 4x12 15th NW</u>		Address <u>4x12 15th NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4 and DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/14/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Shawville Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. N. Horton</u>		ADDRESS <u>1322 U.S. Hwy</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 hr.</u>		d. STREET ADDRESS <u>4604 Aspen Hill Rd S.S.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tubercular Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Tataro</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9 1939</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Edward Tataro</u>		14. MOTHER'S MAIDEN NAME <u>Grace Tataro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Edward Tataro 4604 Aspen Hill Rd</u>	
17. INFORMANT <u>Mr. Edward Tataro</u>		Address <u>4604 Aspen Hill Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u>			
825X DUE TO <u>Focal Cerebral Hemorrhage</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u>Fracture of the skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of the skull</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury in auto involved in accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2:10 p.m.</u> <u>8-16</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Residence</u>		20f. (City or town) (County) (State) <u>Rockville Maryland MD</u>	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschat</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschat</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lewis</u>		ADDRESS <u>Wm. J. Lewis, R.T.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/35



9366

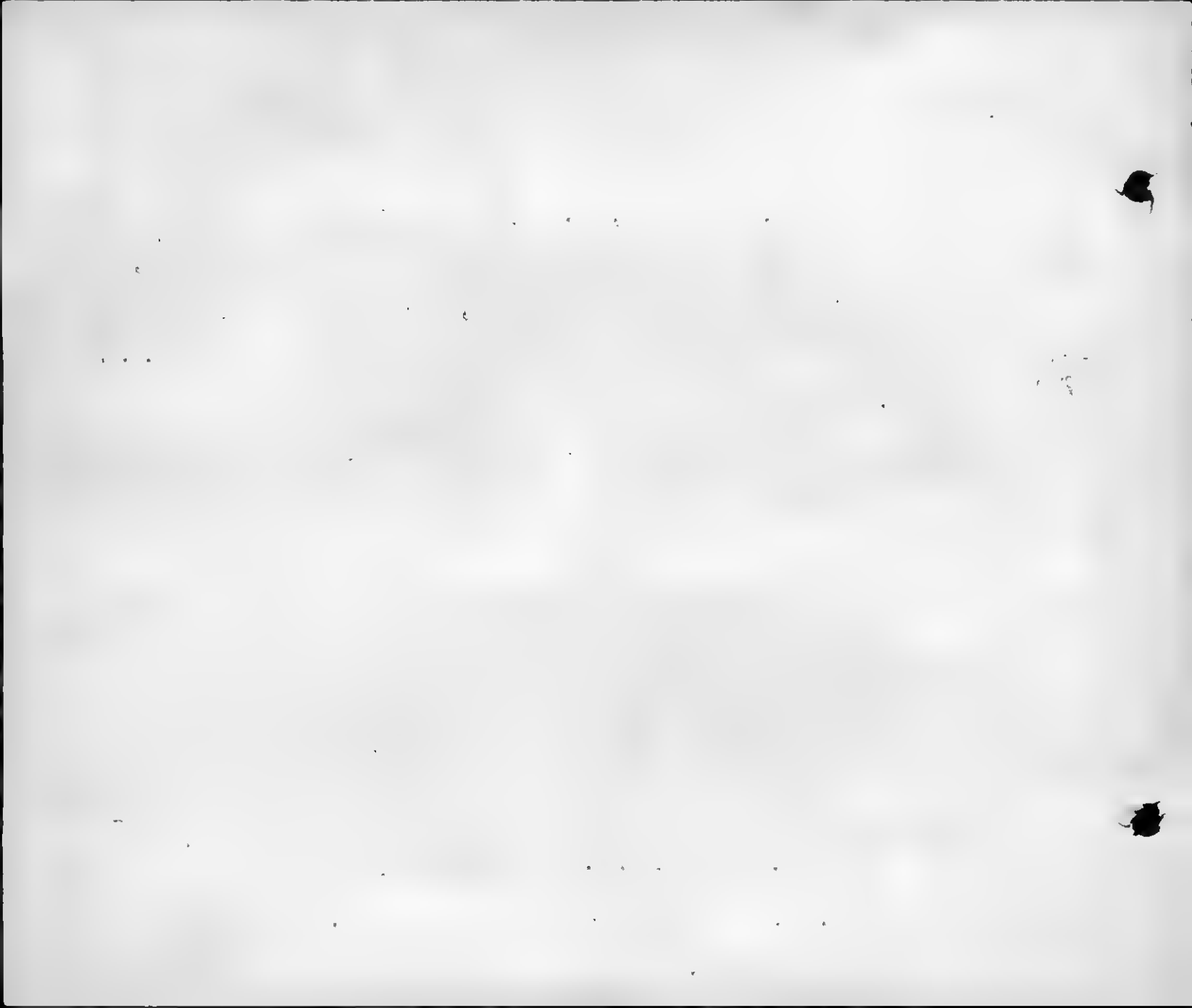
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) ✓ a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>3933 Usher Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Wade</b> Middle <b>Hampton</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1959</b>		9. AGE (In years last birthday) yrs <b>3</b> Months <b>4</b> Days <b>4</b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Lindsey H. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Helen West</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> DUE TO <b>7 + 5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29</b> , 19 <b>59</b> to <b>August 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 8</b> , 19 <b>59</b> , and that death occurred at <b>4:00 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Vincent T. Andriole</b>		M.D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state) <b>National Institutes of Health</b>		DATE SIGNED <b>8-8-59</b>	
PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M. D.</b>		ADDRESS <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Every Funeral Home, Fairfax, Virginia</b> By <b>Manager</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

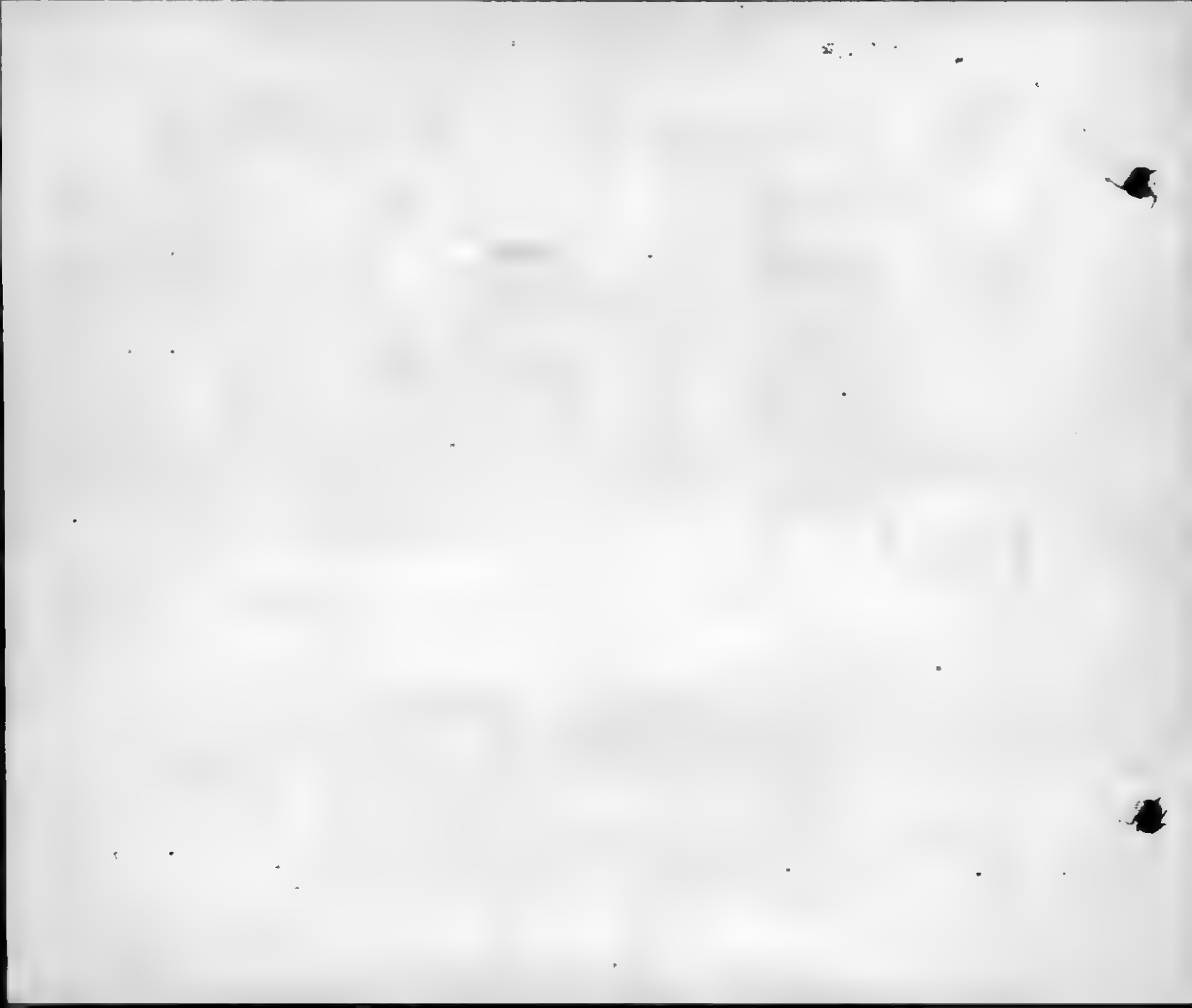
9367

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09335

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9941 Mayfield Drive</b>		d. STREET ADDRESS <b>9941 Mayfield Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>HUGH</b> Middle <b>R.</b> Last <b>THOMAS</b>		4. DATE OF DEATH <b>Aug</b> <b>May</b> <b>15</b> , <b>19</b> <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur W. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Alice Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wife</b> <b>Eunice B. Thomas</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>400.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Found dead in bed.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>Aug. 15, 1959</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>Aug 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William J. King</b>			





9368

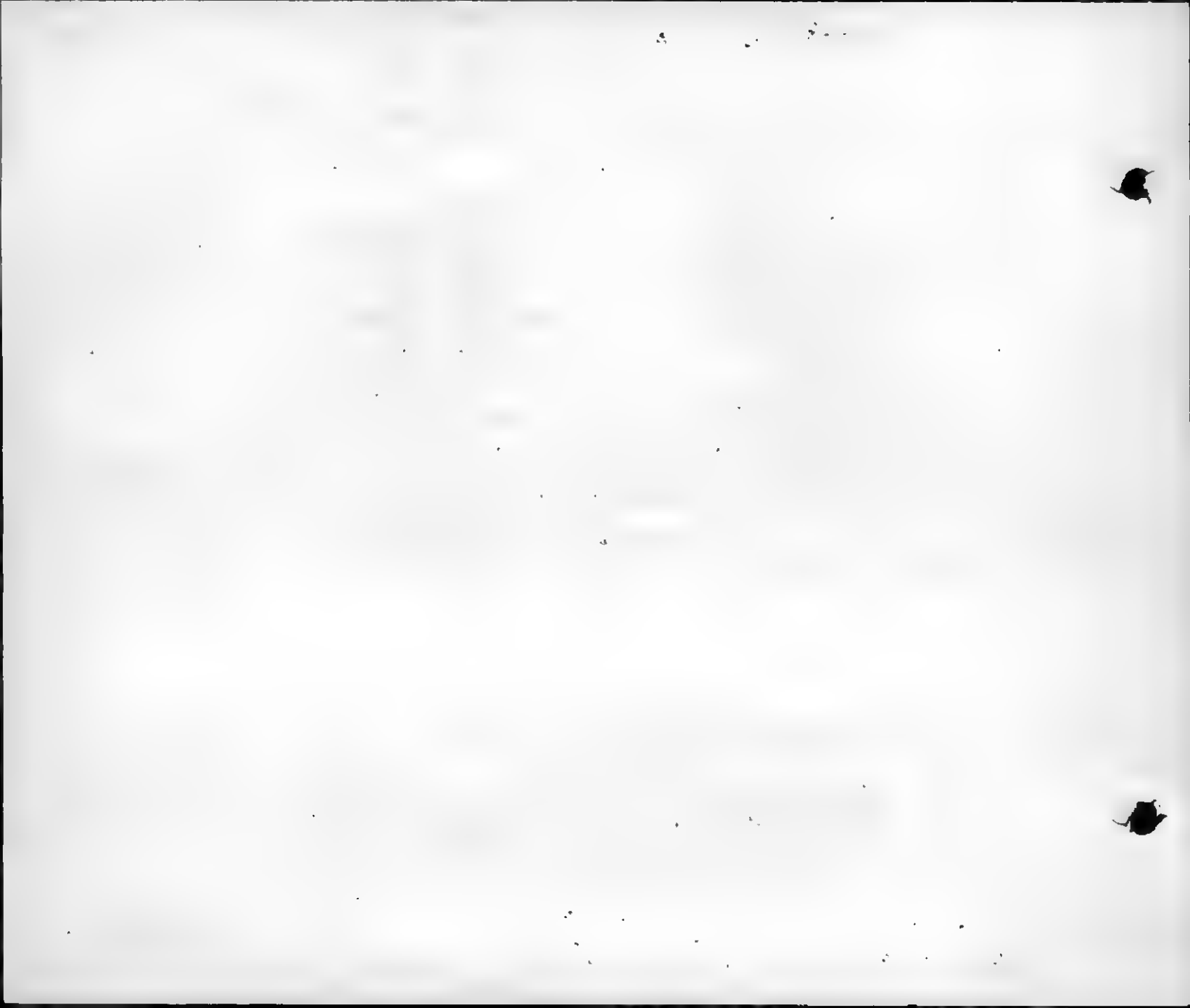
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>35 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolsville</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>W</u> Last <u>Titus</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Separated</u>		8. DATE OF BIRTH <u>1/17/07</u>	
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> Hours <u>19</u> Min. <u>59</u>		11. IF UNDER 24 HRS Months <u>5</u> Days <u>12</u> Hours <u>19</u> Min. <u>59</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Station Attendant</u>				10c. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
13. FATHER'S NAME <u>John Franklin Titus</u>				14. MOTHER'S MAIDEN NAME <u>Annie Frye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>210-07-9074</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				18. INFORMANT <u>Sister (Mrs. Anna Brooks)</u> Address <u>Poolsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Emphysema</u> DUE TO (b) <u>Bronchopneumal Foci</u> DUE TO (c) <u>6 mm</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mm</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>59</u> , to <u>Aug 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>59</u> , and that death occurred at <u>10:15</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George William Ware</u>				ADDRESS (Street, city or town, state) <u>900-176 St. H. W.</u> DATE SIGNED <u>8/12/59</u>			
PHYSICIAN'S NAME (Type) <u>Wm. B. Hilton</u>				22a. REC'D BY REGISTRAR <u>Aug 18 '59</u>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22c. DATE THEREOF <u>Aug 15-59</u>			
22d. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>				22e. LOCATION (City, town, or county) (State) <u>Beallsville Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton</u>				24. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9369. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09337

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1016 Street st</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1016 Street st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Chesley</u> Last <u>Trout</u>				<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>21</u> Year <u>1957</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-18-1880</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bakery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Joseph Trout</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Amanda Grey</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Muri Trout</u> Address <u>Home 2</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input "="" checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.       </b>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>8-21-57</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <u>8/24/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cem.</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Bladensburg Road, Maryland</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. J. Thompson</u>				<b>ADDRESS</b> <u>5732</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Aug 26 '57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton S. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9227

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>FLORIDA</u> b. COUNTY <u>St. Petersburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>			
c. LENGTH OF STAY IN 1b <u>45 min</u>				d. STREET ADDRESS <u>1054 55th Avenue N.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Lloyd Tubman</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>m.</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>Names</u>		13. FATHER'S NAME <u>HARRY I. TUBMAN</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE A. SIMMONS</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Hosp. records 7600 Carroll Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Coronary sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. (day)</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8/25/1959</u> to <u>8/25/1959</u> , that I last saw the deceased alive on <u>8/25/1959</u> , and that death occurred at <u>1030 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md.</u>				DATE SIGNED			
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

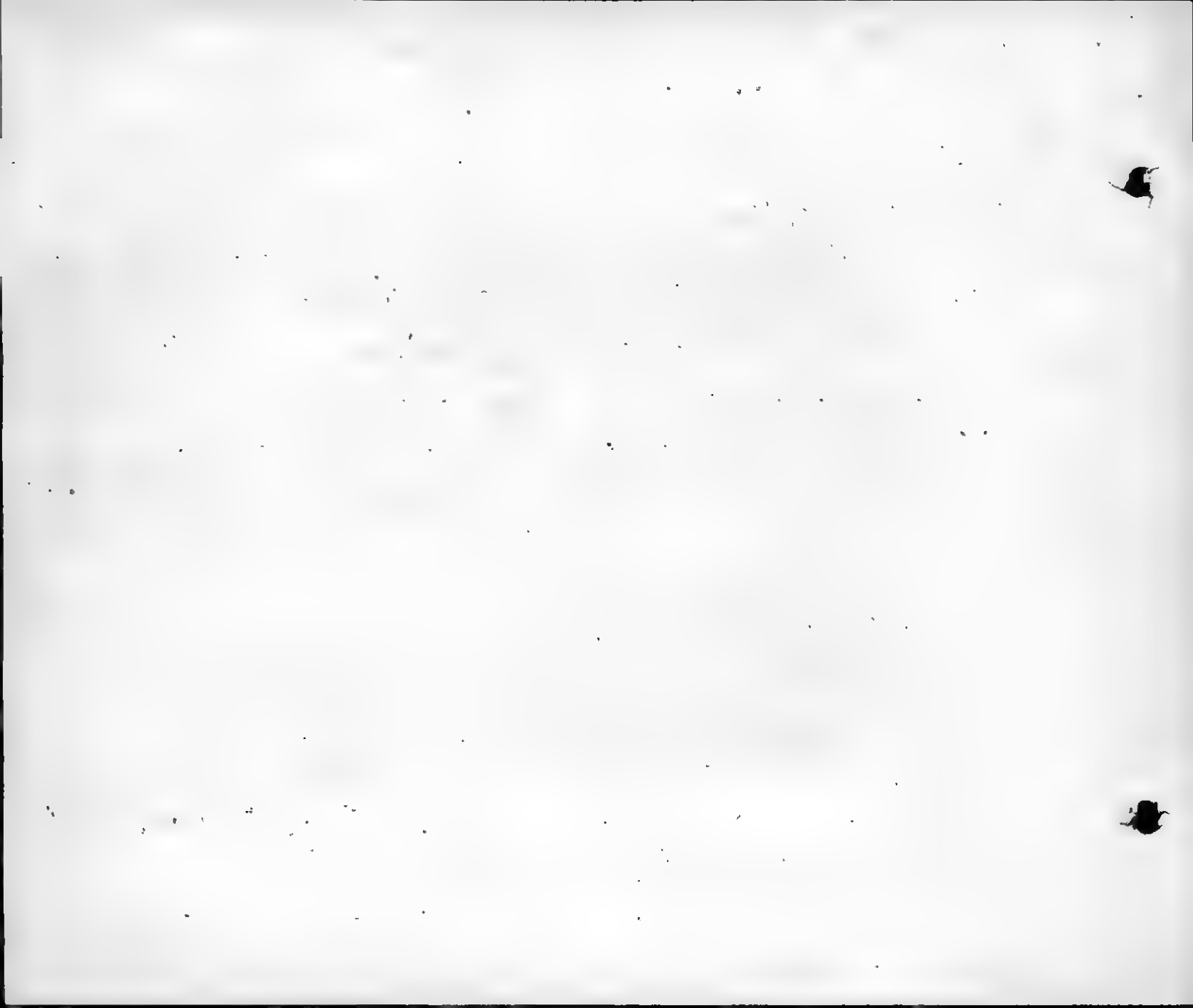
9370

## CERTIFICATE OF DEATH

Reg. Dist. No.

09339

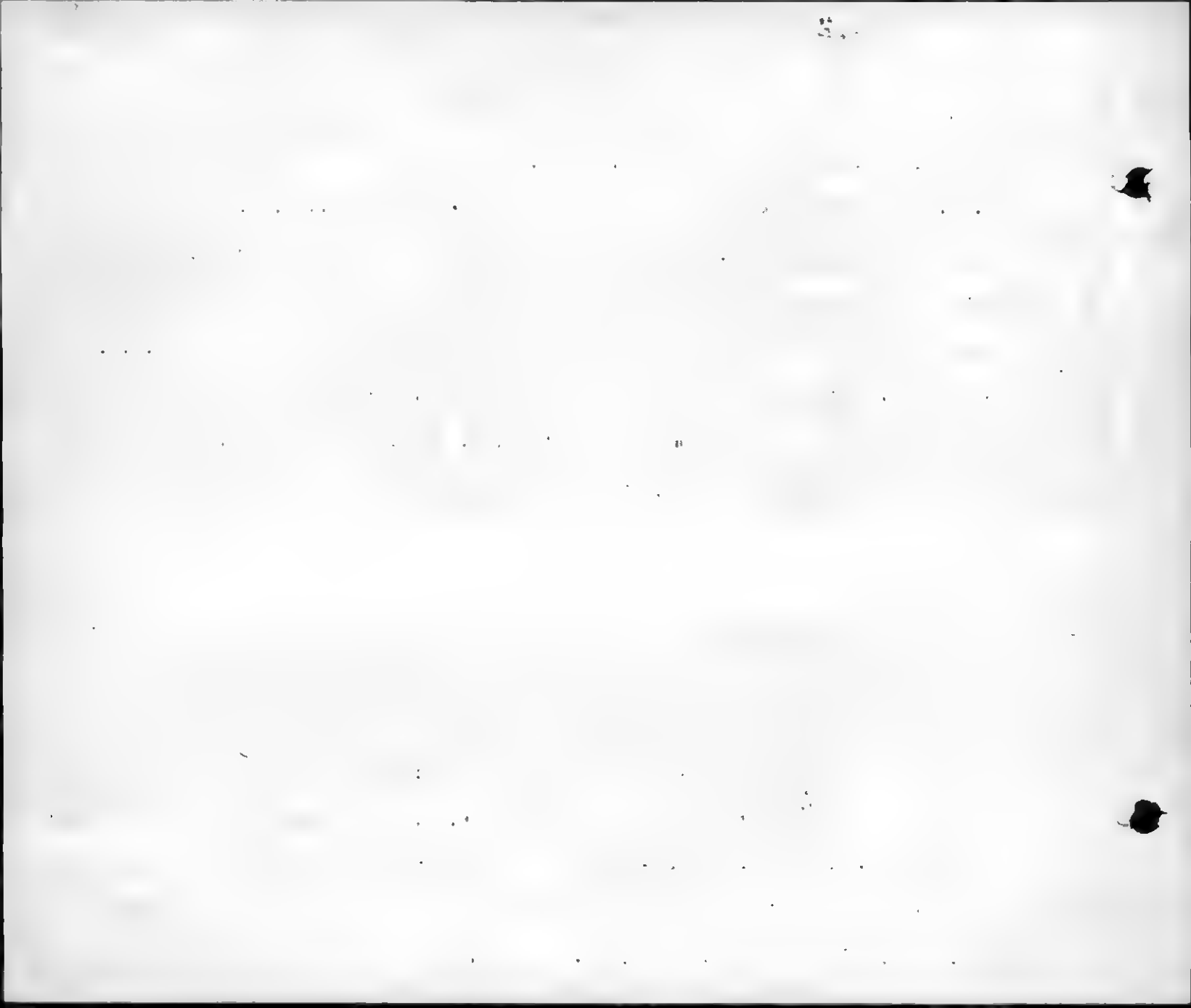
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>		c. LENGTH OF STAY IN lb <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5500 Newington Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>G.</u> Last <u>TUFTY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Minn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Jonas O. M. Tufty</u>	
14. MOTHER'S MAIDEN NAME <u>Teena Wigsdal</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>358-07-4764</u>		INFORMANT <u>Edith H. Tufty-wife-same as 2d</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. Broochart notified and released</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> , to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>undetermined</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. DuChes</u> M.D.		ADDRESS (Street, city or town, state) <u>5500 Newington Rd Bethesda, Md</u> DATE SIGNED <u>8/29/59</u>	
PHYSICIAN'S NAME (Type) <u>John W. DuChes</u>		<u>2010 Wash. 9, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>9/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deluth, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			





1  
 TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9371									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN lb <b>1 hr. 40 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>2474 Alabama Ave., S. E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Twin "A")</b>			First <b>WADE</b>		Last <b>WADE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 59</b>		
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-15-59</b>		9. AGE (In years last birthday) yrs. <b>1</b> Min. <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wallace R. WADE</b>					14. MOTHER'S MAIDEN NAME <b>Eileen V. VINCENT</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) W. R. Wade, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity with immaturity</b> <b>176X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>12:05A</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>F. De Paola</b>					ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>8-17-59</b>		
PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>					ADDRESS <b>Bethesda 14, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Jarvis Funeral Home</b>					ADDRESS <b>1432 U St. NW, Wash. DC</b>		24a. REC'D BY REGISTRAR <b>AUG 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/58

9372

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

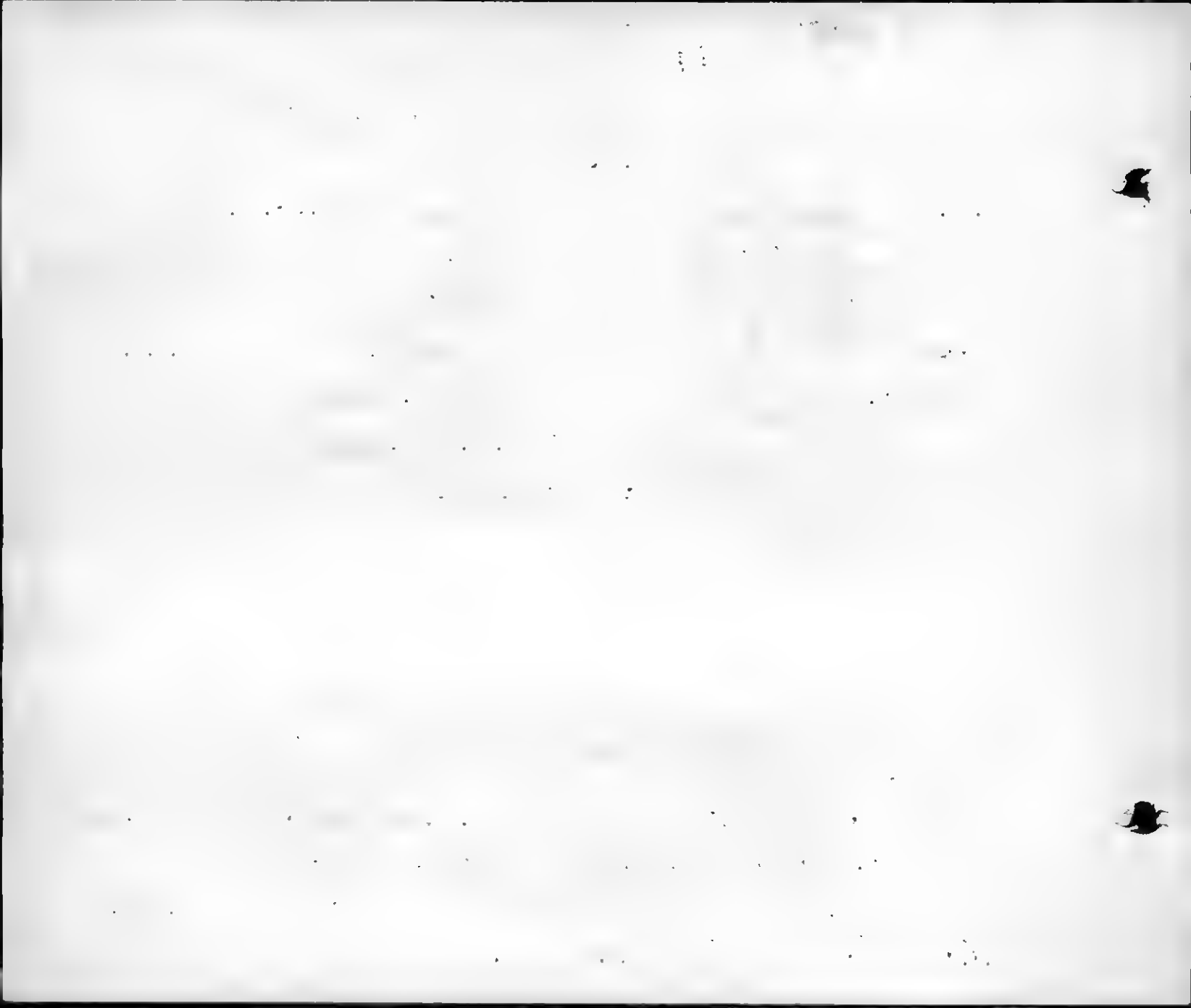
09341

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 hrs. 48 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2474 Alabama Ave., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>(Twin "B")</b> Middle <b>WADE</b> Last <b>WADE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-59</b>
9 AGE (In years last birthday) yrs. <b>47</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>48</b>	IF UNDER 24 HRS. Hours <b>4</b> Min <b>48</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wallace R. WADE</b>	
14. MOTHER'S MAIDEN NAME <b>Eileen V. VINCENT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) W. R. Wade, same as #2 above</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity with immaturity</b> DUE TO <b>7/16X</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>(b) DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-17-59</b>			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Jarvis</b> ADDRESS <b>W.E. Jarvis Funeral Home, 1432 U St. NW, Wash. DC</b>		24a. REC'D BY REGISTRAR <b>AUG 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

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9234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>230 FALLS ROAD</b>				/ d. STREET ADDRESS <b>230 FALLS ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>L.</b> Last <b>WARD</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1867</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George M. Fry</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Stout</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Norman E. Ward</b>			
				Address <b>127 S. Adams Street Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral Thrombosis</b> (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>48 hrs</b> <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Broncho pneumonia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/1/59</b> to <b>8/9/59</b> , that I last saw the deceased alive on <b>8/9/59</b> , and that death occurred at <b>11:55 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.				ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Stephen Jones</b>				<b>- Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>				ADDRESS <b>Rockville, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 12 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carol A. Hines</b>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9373

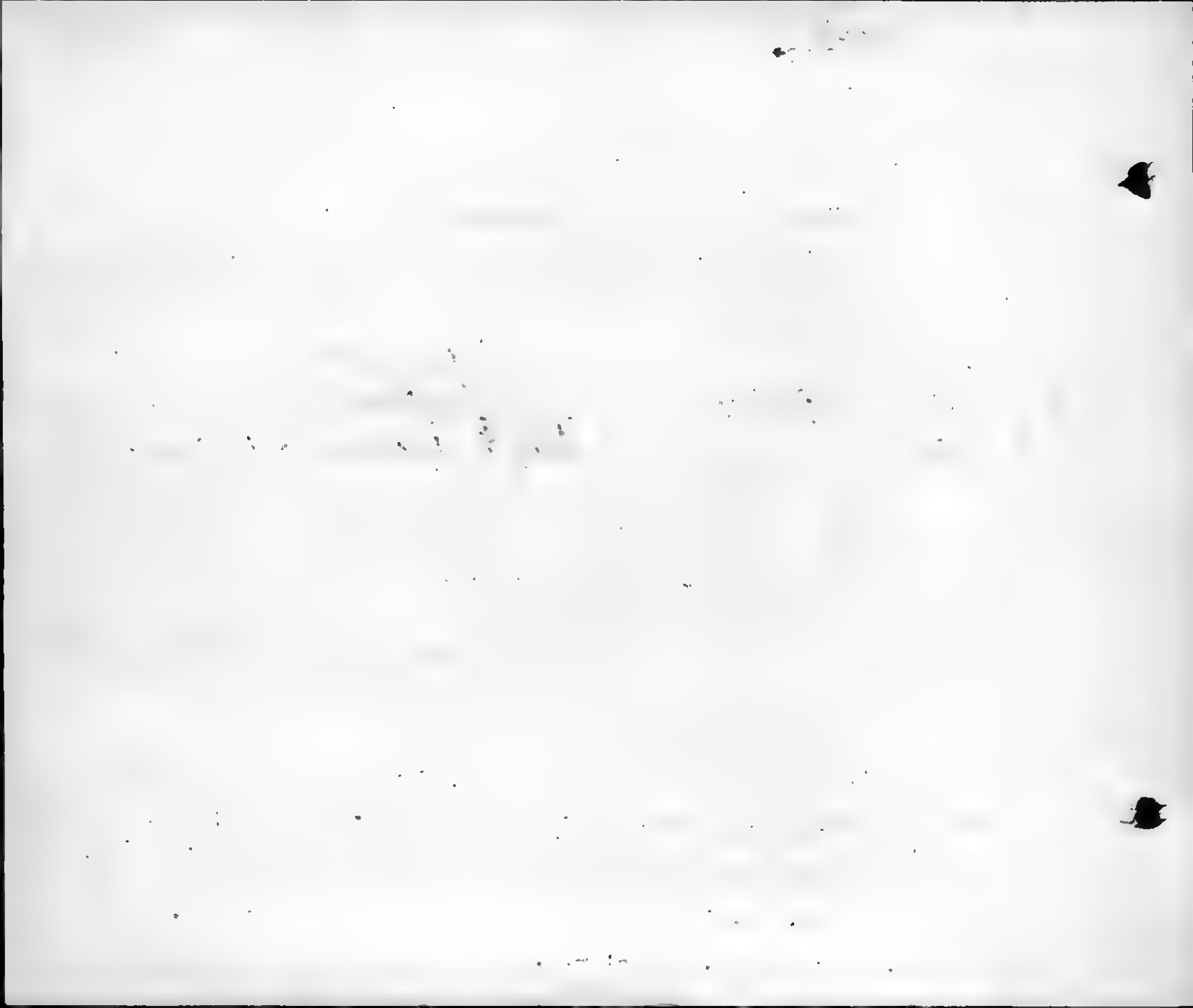
## CERTIFICATE OF DEATH

09343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. STREET ADDRESS <b>3902 Knowles Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Marjorie</b> Middle <b>C.</b> Last <b>Warren</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/93</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min <b>59</b>	11. IF UNDER 24 HRS Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ingram</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Ruby C. Connor</b> Address <b>Alexandria, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coarctation and Shock</b> <b>199.2</b> DUE TO <b>Internal haemorrhage (gastro-intestinal, uterine)</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Obstructive jaundice</b> (c) <b>Generalized Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>59</b> , to <b>Aug 10</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug 10</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon Rosenberg</b> M.D.		ADDRESS (Street, city or town, state) <b>2614 SEASIDE AVE. 10th and 19th</b>	
PHYSICIAN'S NAME (Type) <b>Gordon Rosenberg</b>		DATE SIGNED <b>GAITHER/ABURY, W.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Aug. 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>Danville, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>
ADDRESS <b>2901-14-St. NW</b>		<b>Wash, DC</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9374

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>6 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>Stewards Lane</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Arthur</i>		First <i>Washington</i>		Middle <i>Washington</i>		Last <i>Aug</i>	
4. DATE OF DEATH <i>Aug 23 1959</i>		Month <i>23</i>		Day <i>1959</i>		Year	
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/16/08</i>	
9. AGE (In years last birthday) <i>51</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Marshall Washington</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Green</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT <i>Gertrude Washington, Stewards Lane</i>		Address <i>Silver Spring</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>ACUTE MYOCARDIAL INFARCTION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CORONARY OCCLUSION</i> (c) <i>CORONARY ARTERIOSCLEROTIC HEART DISEASE UNDETERMINED</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 HRS</i> <i>6 HRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/23/1959</i> to <i>SAME</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8/23/1959</i> , and that death occurred at <i>3:55 P.M.</i> from the causes and on the date stated above							
ACTUAL SIGNATURE <i>John H. Dohy</i>		M.D. <i>7720 Wisconsin Ave. Bethesda, Md.</i>		ADDRESS (Street, city or town, state) <i>7720 Wisconsin Ave. Bethesda, Md.</i>		DATE SIGNED <i>8/23/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8-27-1959 Good Hope Church</i>		22b. DATE THEREOF <i>8-27-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>COLESVILLE MD</i>		22d. LOCATION (City, town, or county) (State) <i>COLESVILLE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. E. Jannis Co. 1432 York Ave. N.W.</i>		ADDRESS <i>#6553</i>		24a. REC'D BY REGISTRAR <i>AUG 26 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Carol S. Frank</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2042

ACUTE MYOCARDIAL INFARCTION

2042

SECONDARY OCCASION

GOVERNMENT VETERINARIAN FROM DISTRICT

X

2042  
2042

8/23/

25

8/23/

BETHESDA, MD.  
1350 RESEARCH AVE.

St. Joseph's  
Hospital

9375

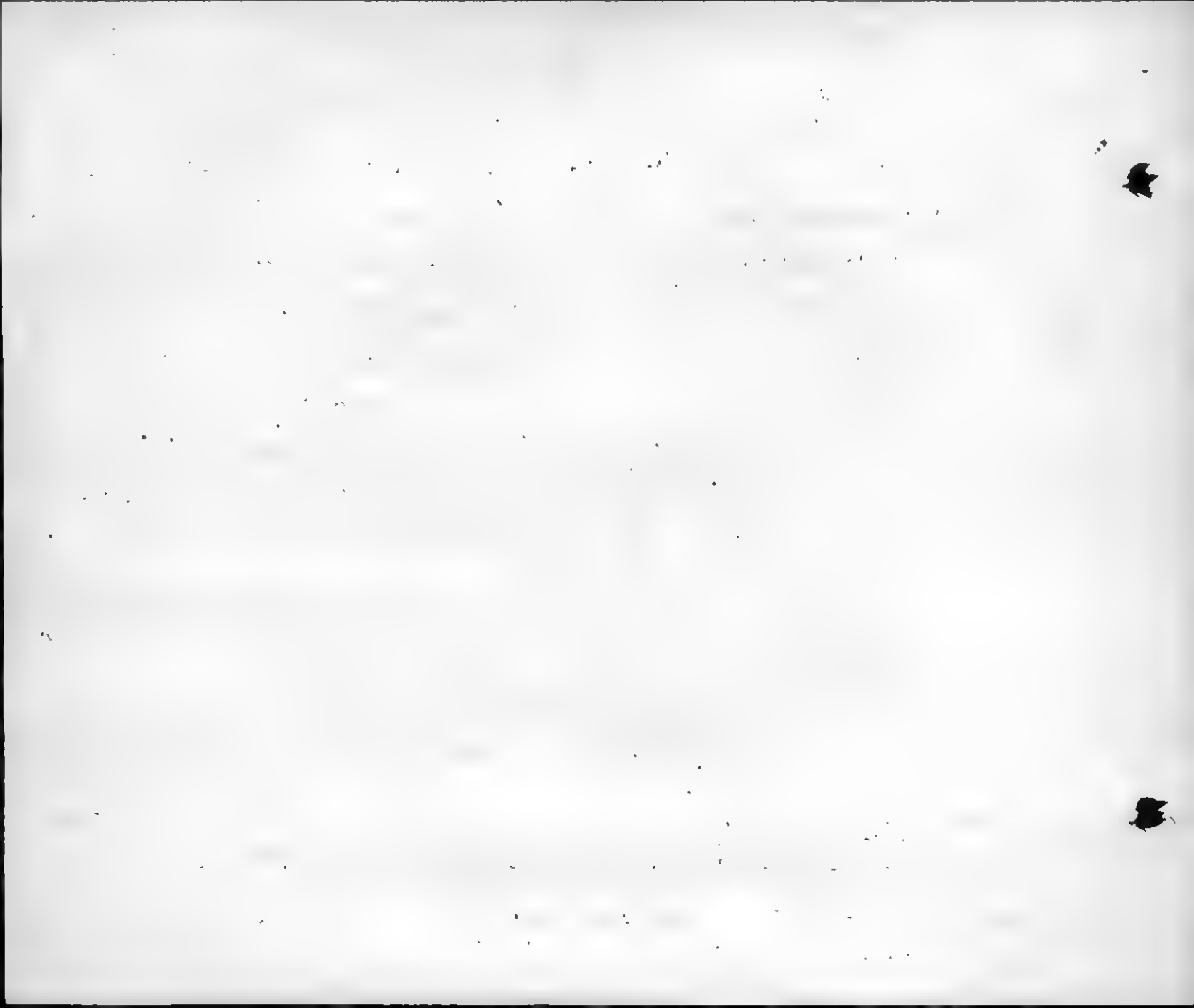
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis</u> <u>XXXXX</u> <u>Weiger</u>		4. DATE OF DEATH Month Day Year <u>Aug</u> <u>2</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>27</u>	11. IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>578-03-2441</u>	
17. INFORMANT <u>Mrs. Ida B. Weiger</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1958, to <u>2 Aug</u> , 1959, that I last saw the deceased alive on <u>2 Aug</u> , 1959, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.S. Murphy</u>		DATE SIGNED <u>3 Aug 59</u>	
PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>		<u>615 W. Montgomery Ave., Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

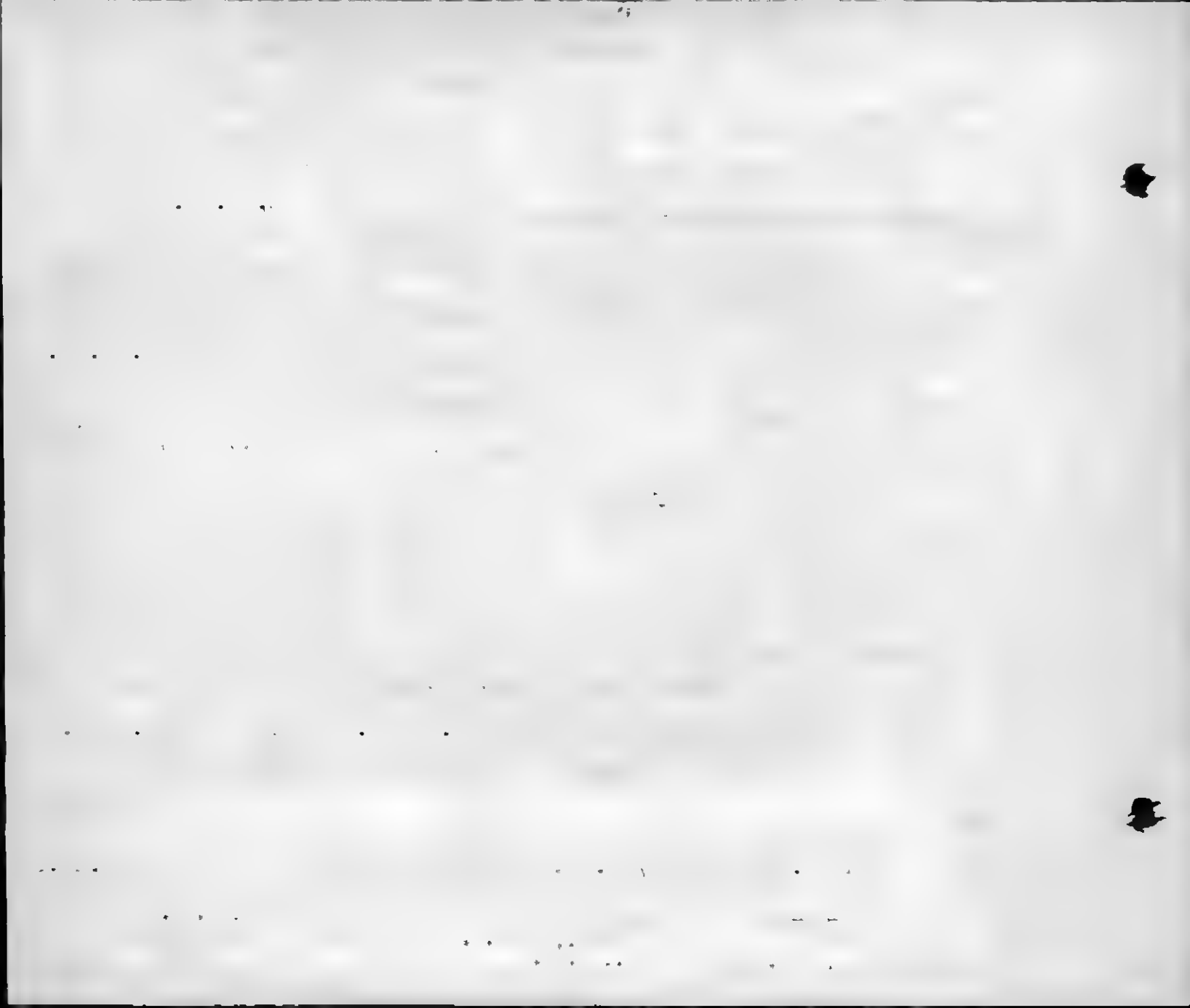


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

<div style="display: flex; justify-content: space-between;"> <span>Item 18 Film 247</span> <span>9376</span> </div> <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;">             09346              Reg. Dist. No.           </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County General Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>D C</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>477 M Street, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Floyd</b> Middle <b>NMN</b> Last <b>Wesley</b>					<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>17</b> Year <b>19 59</b>						
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/25/1892</b>		<b>9. AGE</b> (In years last birthday) <b>67 yrs.</b> <b>10. IF UNDER 1 YEAR</b> Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>South Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Rubin Wesley</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Camilla McCullum</b>						
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>D.C.</b> <b>Alone Groves 206 P St., N.W., Washington.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>[b]</b> DUE TO <b>[c]</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b>										<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>Collapsed while laying brick and fell 4 ft from scaffold</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>11:30 a.m. 8 17 19 59</b>		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Glenmont S. Cntr. Wheaton Montg. Md.</b>		<b>20f. (City or town)</b> (County) (State) <b>Montg. Md.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>											
<b>ACTUAL SIGNATURE</b> <i>Frank J. Broschart</i> <b>M.D.</b>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						
<b>EXAMINER'S NAME (Type)</b> <b>Frank J. Broschart, M. D.</b>					<b>DATE SIGNED</b> <b>8.17.59</b>						
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8-22-1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Washington, D. C.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Malvan &amp; Schey, Inc. 424 "R" St., N. W.</b>					<b>ADDRESS</b> <b>Wash., 1, D.C.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DAN 2 4 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Colman S. Hanks</i>		



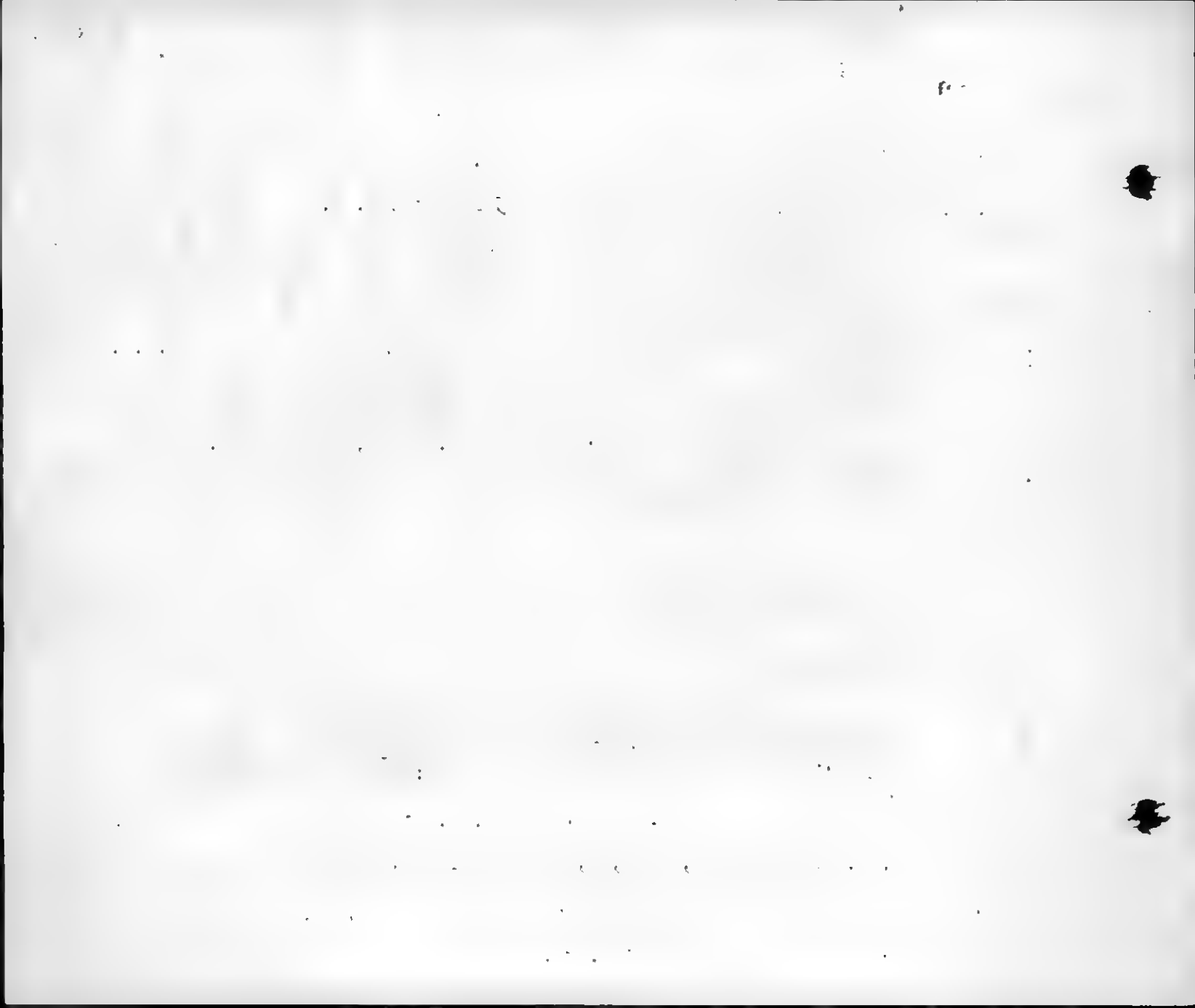
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

Deputy Medical Examiner, Montgomery Co., notified.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9377 CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>132 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b> d. STREET ADDRESS <b>5121 5th Ave. N.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>Fey</b> Last <b>WHITE</b>			4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 59</b>		5 SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-2-07</b>			9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward FEY</b>			14. MOTHER'S MAIDEN NAME <b>Eva GANT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>220-26-4746</b>		INFORMANT <b>(H) John P. White, same as #2 above</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Surgical shock</b> 154X DUE TO <b>Laminectomy for cord stony.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <b>Carcinoma, squamous, rectum</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 years</b>								INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 7</b> , 19 <b>59</b> , to <b>August 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 17</b> , 19 <b>59</b> , and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-17-59</b>									
ACTUAL SIGNATURE <b>W. H. Druckemiller</b> M.D.			PHYSICIAN'S NAME (Type) <b>W. H. DRUCKEMILLER, CAPT, MC, USN</b> <b>Bethesda, Maryland</b>						
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home, 5103 Wisc. Ave. NW, WDC</b>					24a. REC'D BY REGISTRAR <b>AUG 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

*Chevy Chase Funeral Home*





9228

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>31 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edge water</u>	
f. STREET ADDRESS <u>RT. 2 Box 228</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Belle</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-74</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>31</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Reel</u>		14. MOTHER'S MAIDEN NAME <u>Emma McKee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>hospital records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arteriosclerosis of coronary also</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pseudo-bulbar palsy due to basilar artery thrombosis</u> (b) <u>Arteriosclerosis of coronary also</u> (c) <u>Pseudo-bulbar palsy due to basilar artery thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis of coronary also</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16</u> , 19 <u>59</u> to <u>Aug 31</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Aug 30 (30)</u> , 19 <u>59</u> , and that death occurred at <u>3:35</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H. Wolcott</u> M.D.		DATE SIGNED <u>Chas H. Wolcott</u>	
PHYSICIAN'S NAME (Type) <u>Chas H. Wolcott</u>		<u>7600 Carroll Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake</u> <u>Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>251 Carroll St. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

Wm. St. Lawrence, Ac.

1992

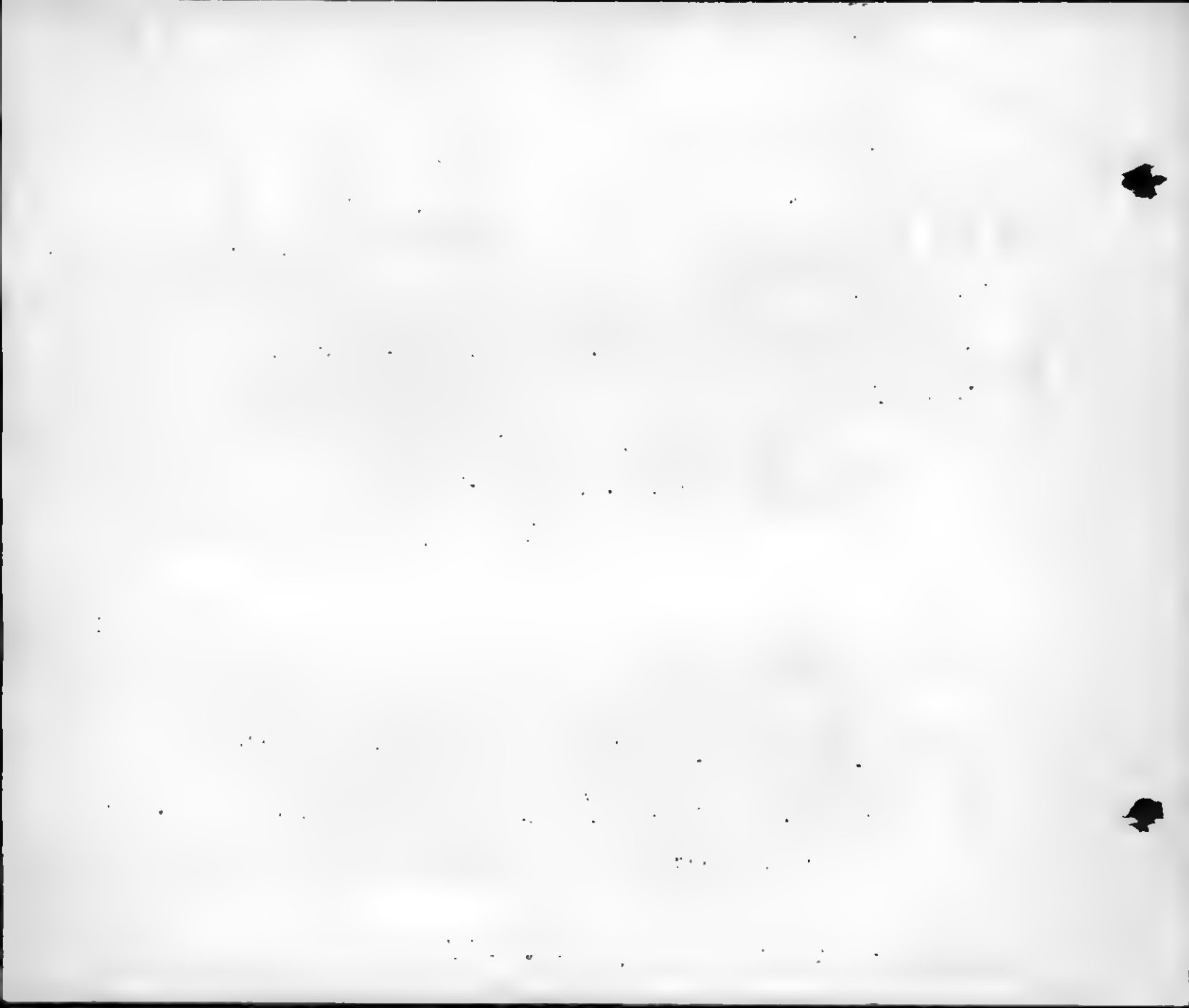
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09349			
9378													
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington, Virginia</b> d. STREET ADDRESS <b>4507 No. Washington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Harry F Williams</b>					4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 5 1881</b>		9. AGE (In years birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Communication</b>					11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Williams</b>					14. MOTHER'S MAIDEN NAME <b>Laura Virginia Welch</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO <b>579-01-6709A</b>					INFORMANT <b>Ida E Williams</b> Address <b>4507-N Washington Blvd. N.A.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>463X Pulmonary Embolism, Massive.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phlebitis Right Leg</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death Immediate</b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Aug 14 1959</b> to <b>Aug 25 1959</b> , that I last saw the deceased alive on <b>August 24 1959</b> , and that death occurred at <b>7:20a</b> M, from the causes and on the date stated above.													
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>					ADDRESS (Street, city or town, state) <b>10609 Concord Street</b>					DATE SIGNED <b>August 25, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>					<b>Kensington, Maryland</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>8/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert T. Thibadeau</b>					ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR <b>AUG 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>				
<b>Arlington Funeral Home 3901 No. Fairfax Drive</b>													

2

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

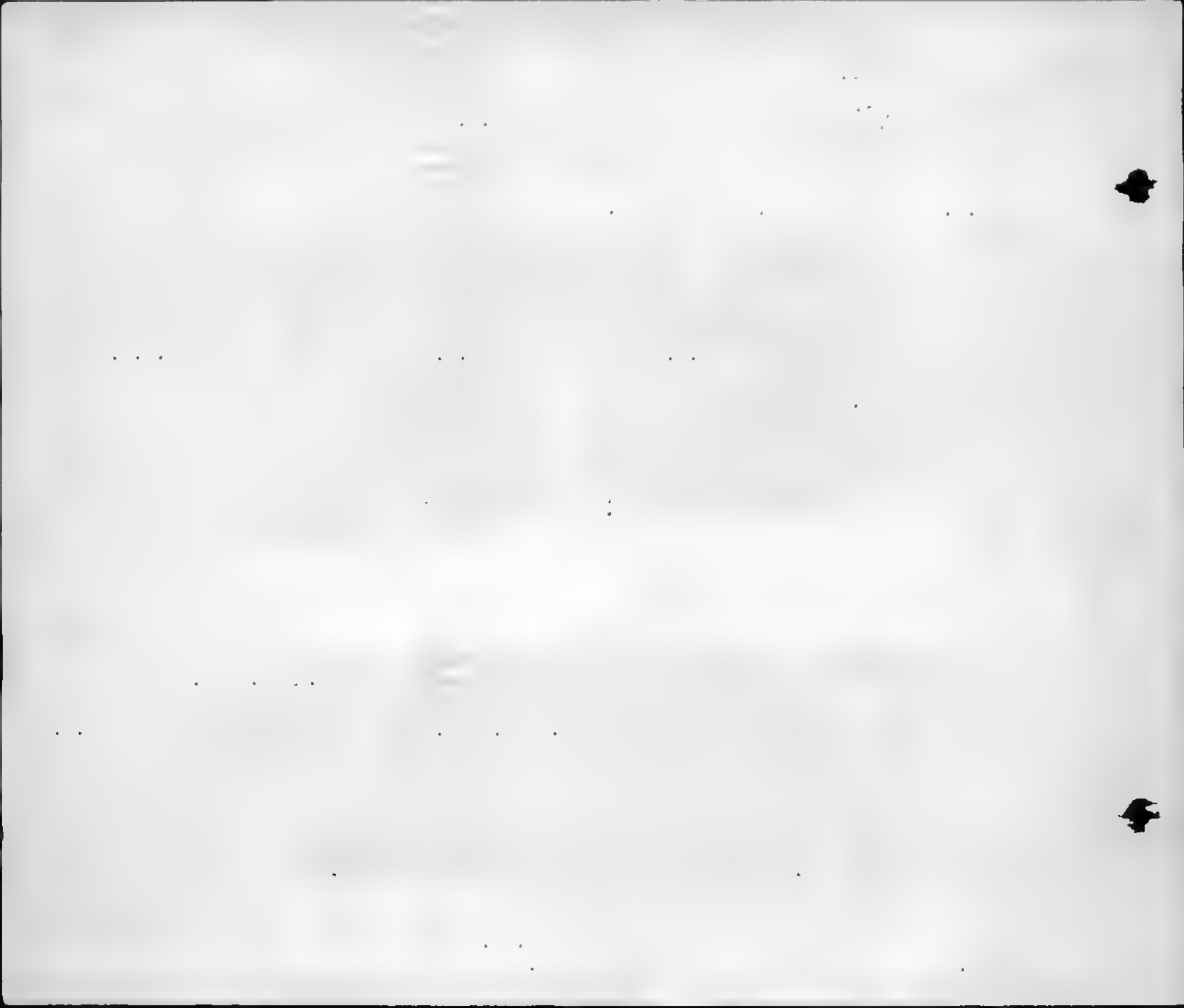
9379

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09350

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N.H.</b> b. COUNTY <b>Hillsboro</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b> d. STREET ADDRESS <b>68 Appleton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN Frederick WILLIAMS</b>			4. DATE OF DEATH Month Day Year <b>August 2 19 59</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5-1-39</b>		9. AGE (In years last birthday) <b>20 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman apprenticeship</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>N.H.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Frederick A. WILLIAMS</b>			14. MOTHER'S MAIDEN NAME <b>Mildred (Unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes present time</b>		16. SOCIAL SECURITY NO. <b>003-26-2976</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lower nephron nephrosis and uremia</b> <b>857X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple crushing injuries and amputations,</b> DUE TO <b>traumatic</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11 days</b> <b>11 days</b> INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was crushed between ship and dock at N. Rec. Lab. DC</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>7-22-59</b> p. m.		20d. INJURY OCCURRED White of work <input checked="" type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N. Rec. Lab. DC</b>	
20f. (City or town) <b>Washington</b>		20g. (County) <b>D.C.</b>		20h. (State) <b>D.C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-3-59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manchester New Hampshire</b>	
22d. LOCATION (City, town, or county) <b>Manchester</b>		22e. (State) <b>New Hampshire</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>Wash, D. C.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>W.W. Chambers</b>					



9380

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>337 Chinlee Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>WILLIS, JR.</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-59</b>
9. AGE (In years last birthday) yrs. <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. WILLIS</b>		14. MOTHER'S MAIDEN NAME <b>Mary PULLIAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity (32 wks)</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30</b> 19 <b>59</b> to <b>August 5</b> 19 <b>59</b> , that I lost saw the deceased alive on <b>August 5</b> 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital</b> <b>8-6-59</b>			
ACTUAL SIGNATURE <b>G. B. Avery</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1982

Attorneys (Hunt)

U. S. Court House

John

Commission

Man

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How

Hospital records

Exhibit 1 (22-000)

July 1982

U. S. Court House

Theodore M. H. H. H.

U. S. Court House

Washington D. C.

Attorney

U. S. Court House



9381

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>105 Hesketh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Brent YOUNG</b>		4. DATE OF DEATH Month Day Year <b>August 15 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-18-88</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William B. YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>Alice C. JONES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>	
17. INFORMANT <b>Robt. L. Young, 4213 Rosedale Ave., Bethesda, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive coronary occlusion, posterior infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>years</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 3</b> , 19 <b>59</b> , to <b>August 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 15</b> , 19 <b>59</b> , and that death occurred at <b>9:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital</b> <b>8-15-59</b>			
ACTUAL SIGNATURE <i>C. W. Bramlett</i> PHYSICIAN'S NAME (Type) <b>C. W. BRAMLETT, LT, MC, USN</b>		M.D. <b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joe Gawley</i> ADDRESS <b>Joe Gawley &amp; Sons, 1756 Penn. Ave., NW, Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

1260

(1947)

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957